QUALITATIVE EXPLORATIONS OF THE FACTORS INFLUENCING THE SELECTION OF THE COPPER INTRAUTERINE DEVICE AS A METHOD OF EMERGENCY CONTRACEPTION

by

Rachel Lee Wright

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STATEMENT OF DISSERTATION APPROVAL

The dissertation of **Rachel Lee Wright**

has been approved by the following supervisory committee members:

Caren J. Frost	, Chair	**4-26-2012** Date Approved
Jason Castillo	, Member	**5-7-2012** Date Approved
David S. Derezotes	, Member	**4-26-2012** Date Approved
Mary Jane Taylor	, Member	**4-26-2012** Date Approved
David K. Turok	, Member	**4-26-2012** Date Approved

and by **Jannah Mather**, Chair of the Department of **College of Social Work**

and by Charles A. Wight, Dean of The Graduate School.

ABSTRACT

Unintended pregnancy remains a significant issue in the United States. Despite increasing access to oral emergency contraception, the rates of unintended pregnancy and abortion have failed to decrease. The copper intrauterine device (copper IUD) is both a highly effective method of long-term contraception and emergency contraception when inserted within 120 hours of unprotected intercourse. However, the use of the copper IUD remains low among women in the United States. At present, research focuses on oral emergency contraception and on the individual characteristics of women and their use of emergency contraception. This dissertation explores the factors influencing a woman's emergency contraceptive method selection, and the impact of health care providers and male partners. Three separate articles are presented which were submitted for publication in peer-reviewed journals.

I dedicate this dissertation to the strong women in my family: Amelie, Stephanie, Angela, Karen, Marsha, Willy, and Jeanne. Thank you.

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CHAPTER 1

INTRODUCTION

Overview of the Problem

Investigating the prevention of unintended pregnancy is a topic relevant to the field of social work because of the significant negative consequences on women, children, men and society. Unintended pregnancy is defined as a pregnancy that is either unwanted or mistimed. Women are considered to be at high risk of an unintended pregnancy if they engage in unprotected heterosexual intercourse or if they experience a contraceptive method failure. Consequences permeate the health, safety, economic security, and overall development of women and children involved with an unintended pregnancy.

Societal Consequences of Unintended Pregnancy

Unintended pregnancy also presents numerous public health and societal consequences. Nearly half of all pregnancies in the United States are classified as unintended, a rate remaining unchanged since 1994. This number translates into an estimated 3.1 million unintended pregnancies occurring in 2001, resulting in approximately 1.3 million abortions and 434,000 fetal losses (Finer & Henshaw, 2006). According to new estimates, unintended pregnancy costs the U.S. over $11 billion each

year (Sonfield, Kost, Gold & Finer, 2011). However, despite its prevalence, unintended pregnancy remains an understudied area. This gap may be due to stigma attached to defining one's pregnancy as unintended, the difficulty of measuring pregnancy intendedness, and its disproportionate effects on young, low-income women.

Consequences for Children

Women at high risk of unintended pregnancy often engage in unhealthy behaviors, such as smoking during a pregnancy and obtaining inadequate prenatal care, that can lead to adverse pregnancy outcomes and later poor developmental outcomes for their children. Women with an unintended pregnancy may be less motivated to change behaviors that would benefit a fetus because of more immediate physical and emotional needs (Hellerstedt el al., 1998). After controlling for demographic characteristics, women at high risk are significantly more likely to smoke and be obese, and less likely to have had a recent Pap test or sexually transmitted infection (STI) counseling compared to their lower risk counterparts (Xaverius, Tenkku & Salas, 2009). Children born from an unintended pregnancy are more likely to have low birth weight, be abused, and to die within their first year of life (Brown & Eisenberg, 1995). Unwanted and mistimed children receive fewer skill development resources, and have lower vocabulary attainment at preschool age than children from a wanted pregnancy (Baydar, 1995).

Consequences for Women

An unintended pregnancy further threatens a woman's safety and wellbeing. Women with an unintended pregnancy are at an increased risk of physical abuse during

pregnancy compared to women whose pregnancy is intended (Goodwin, Gazmararian, Johnson, Gilbert & Saltzman, 2000). Unintended pregnancy is also positively associated with mental health symptoms such as anxiety and depression among women (Gipson, Koenig & Hindin, 2008). A woman's relationship is at a greater risk of failing when an unintended pregnancy occurs, leaving her in an economically vulnerable position (Brown & Eisenberg, 1995). Unintended pregnancy is highest among women with less than a high school degree and minorities, and has increased by 29% among low-income women since the mid-1990s (Finer & Henshaw, 2006). While men also experience its adverse effects, these are outside the scope of this dissertation.

Women at high risk of an unintended pregnancy additionally report barriers to consistent contraceptive use such as lack of health insurance, fear of method side effects, and dislike of available methods (Vaughn, Trussell, Kost, Singh, & Jones, 2008; Foster et al., 2004). While many existing interventions and programs focus on unprotected sex among adolescent populations, data from the National Survey of Family Growth (NSFG) suggest that women aged 18-19 and 20-24 are equal in their level of non-contraceptive use and are significantly more likely to be sporadic users (Glei, 1999). These findings highlight the need for research and social work interventions aimed more broadly at young adult female populations.

Options to Decrease Unintended Pregnancy

Although high rates of noncontraceptive use persist among young adult populations, current options exist to help lower a woman's risk of an unintended pregnancy. Research indicates that emergency contraception (EC) is highly effective in

reducing the risk of unintended pregnancy when taken within 120 hours of unprotected sexual intercourse (Trussell, Ellerston, Stewart, Raymond & Shochet, 2004). The most common methods of EC are progestin or estrogen-containing pills available either over the counter to women and men over 18 years of age or through healthcare clinics. The use of EC pills is considered safe for nearly all women, and is shown to decrease the risk of pregnancy by 75%. EC pills delay or prevent ovulation, and may additionally inhibit fertilization. Research further indicates that the use of EC pills has no effect on an established pregnancy (Trussell, et al., 2004).

EC is shown to be highly cost effective because it significantly reduces medical expenditures by preventing unintended pregnancy (Trussell, Koenig, Ellertson & Stewart, 1997). Increased access to EC followed the 2006 Federal Drug Administration (FDA) decision to make EC pills available over the counter. Yet results from a recent systematic review suggest that increased access to EC has decreased neither unintended pregnancy nor abortion rates at the population level in the United States (Raymond, Trussell & Polis, 2007). EC's failure to decrease unintended pregnancy suggests alternatives to EC pills must be investigated. Promoting an effective method of EC that can continue to provide highly effective, long-term contraception may result in reducing unplanned pregnancy rates among EC users.

The Copper Intrauterine Device

Most research focuses on EC pills when investigating experiences with, barriers to, and perceptions about EC. A copper intrauterine device (IUD) may be inserted as a form of EC up to 7 days following ovulation, and prevents a pregnancy even if

fertilization has occurred (Trussell, et al., 2004). While it is initially more costly than EC pills, a copper IUD can provide highly effective continuous contraception for up to 12 years. The copper IUD is a small, t-shaped device wrapped in copper wire inserted into the uterus, and prevents fertilization by killing sperm and altering the uterine lining. The copper IUD results in more savings than EC pills after only a four-month period (Trussell, et al., 1997).

The copper IUD may potentially impact unintended pregnancy beyond its function as EC. The American College of Obstetricians and Gynecologists (ACOG) posits that the high rate of unintended pregnancy in the U.S. may be due in part to the low use of long acting reversible contraceptives (LARCs) such as the IUD. LARCs are not only highly effective forms of contraception, but also require little action from users (ACOG, 2009). Table 1.1 details common contraceptives by their effectiveness.

Table 1.1: Contraceptive Effectiveness

Method	**Effectiveness**
Implants, IUD, Sterilization	Highly Effective (less than 2% failure rate)
Oral Contraceptive pills, Contraceptive Patch, Vaginal Ring, Depo-Provera	Effective (3-8% failure rate)
Condoms (male and female), Withdrawal, Spermicide, Cervical Barrier methods, Fertility Awareness methods	Less Effective (more than 8% failure rate)

(Adapted from ACOG, 2009)

Barriers to Contraception

Systemic barriers to adequate contraception and EC persist. The constitutional right to contraception began with the 1965 Supreme Court decision in *Griswold v. Connecticut*, which recognized access to contraception as a fundamental component of individual privacy. Nonetheless, hospitals are not required to offer EC to victims of sexual assault, and individual states continue to allow insurance plans, healthcare providers and pharmacists to refuse the coverage, prescribing, or dispensing of contraception and EC due to moral or religious objection. These conscience clauses may protect the moral views of some, but severely undermine a woman's control over her reproductive health care (Laspina, Mathison, & Preston, 2010). Furthermore, abortion rates among low-income women have drastically increased within the last decade. This increase is attributed to a woman's inability to access affordable reproductive healthcare and her perception that she is not capable of supporting a child (Jones & Kavanaugh, 2011). Nonetheless, recent proposed legislation to restrict abortion and contraceptive services in states such as Indiana, Wisconsin, and Florida will further limit a woman's reproductive choices and autonomy.

High rates of unintended pregnancy will persist without exploring barriers to both EC and long-term methods of contraception. Despite their advantages, usage of and knowledge about IUDs remain low among women in the U.S. (Campo, Askelson, Spies & Losch, 2010; Doyle, Stern, Hagan, Hao & Gricar, 2008). This dissertation will investigate perceptions about the copper IUD for EC to better (a) inform practice within fields of providers working with populations vulnerable to unintended pregnancy and (b)

increase our knowledge about how to change to policy connected to reproductive health (Finer & Henshaw, 2006; Homco, Peipert, Secura, Lewis, & Allsworth, 2009).

Factors Influencing a Woman's EC Method Choice

Individual, relational, and systemic factors affect a woman's use and choice of EC method. These factors include her contraceptive needs, her knowledge of EC methods, and the influence of her healthcare providers and male partners. Thus successful interventions should target multiple levels, and account for factors beyond a heterosexual woman's individual characteristics and behaviors (Ayoola, Nettleman & Brewer, 2007). Interestingly, EC research involving either healthcare providers or male partners is scant. To increase the use of IUDs among women seeking EC, research must investigate if women are willing to use the copper IUD, if healthcare providers are willing and able to offer it, and what perceptions male partners have on the copper IUD as a method of EC. This dissertation explores the factors impacting the use of the copper IUD as a form of EC and individual perceptions of EC in order to more effectively reduce the rates of unintended pregnancy and abortion among women in the U.S.

In spite of increased availability, EC has failed to impact the rate of unintended pregnancy and abortion, and use remains low. Out of 90% of women seeking abortion at an antenatal hospital and reporting their pregnancy as unintended, only 11.8% reported using EC in the month they conceived (Lakha & Glasier, 2006). A recent qualitative study further investigated young women's experiences with unprotected sex and use of EC (Williamson, Buston & Sweeting, 2009). The results of this 2009 study indicate that EC is viewed as an important backup contraceptive method, but women often

misperceive their risk of pregnancy following unprotected sexual intercourse and additionally report feelings of failure and irresponsibility for accessing EC. These findings suggest that EC's failure to reduce unintended pregnancy may be related to the social context of when EC is used, meaning a woman's social environment influences her perceptions of unprotected intercourse and her consequent use of EC (Williamson, et al., 2009).

Poor access to contraception remains a significant barrier to continuous contraceptive use for many women (Vaughan, Trussell, Kost, Singh & Jones, 2008). Lack of consistent health insurance may increase the risk of unintended pregnancy and highlights the need for both EC and increased use of long-term methods of contraception. Women without health insurance are more likely to report using (a) no method of contraception or (b) a less effective over the counter method than women reporting having either public or private insurance (Culwell & Feinglass, 2007). Additional barriers such as the high cost of contraceptives, lack of accurate information, and dislike of method side effects further limit a woman's ability to consistently use a method of contraception (Mills & Barclay, 2006; Ayoola, Nettleman & Brewer, 2007; Homco, et al., 2009; Campo, et al., 2010). Use of the copper IUD can reduce a woman's risk of unintended pregnancy due to its ability to function as both a method of EC and as a form of continuous long-term contraception.

Accurate knowledge of EC remains startlingly low in both male and female populations. A study of knowledge, attitudes and behaviors around EC among a university population revealed that 87% of the sample believed EC pills to be mifepristone, a pill that acts as an abortifacient in the first 9 weeks of pregnancy (Corbett,

Mitchell, Taylor, & Kemppainen, 2005). These findings are echoed in a study of women presenting for health care in a rural setting in which 81% were confused by the difference between EC pills and an abortifacient (Fagan, Boussios, Moore & Galvin, 2006). An examination of college students' knowledge and perceptions of EC following the 2006 FDA decision to make it available without a prescription reported that while 94% had heard of EC before the study, only 5% of respondents could identify the correct time period for using it (Vahratian, Patel, Wolff & Xu, 2008). Misperceptions and lack of knowledge may therefore continue to hinder EC use following contraceptive method failure and unprotected intercourse.

There is currently little medical and social work research investigating women's experiences with selecting an IUD as a method of EC when these women present at health clinics for EC. A study of 412 women aged 15-44 attending family planning clinics indicated there is indeed interest in same-day IUD insertion among women seeking EC. Interest in same-day insertion was associated with positive attitudes about the efficacy of the IUD (Schwarz, Kavanaugh, Douglas, Dubowitz & Creinin, 2009; Wright, Frost, & Turok, 2012).

The Influence of Health Care Providers

Health care providers impact a woman's EC use and method choice. The information a woman receives about EC, and her attitudes towards it, are influenced by her healthcare provider's attitudes and perceptions. The majority of female college students surveyed about their EC knowledge and use reported that they would be more likely to use EC if they had heard about it from their providers (Hickey, 2009). A

convenience sample of 524 nurse practitioners, physicians, and physician assistants reveal that 23% of respondents incorrectly understood the risk of infertility with IUD use and nearly 30% could not identify the correct timeframe for EC use (Dehlendorf, Levy, Ruskin, & Steinauer, 2010). These results are worrisome because research indicates that simply receiving information from a healthcare provider impacts a woman's attitude towards an IUD. Young women attending family planning clinics who heard about the IUD specifically from a health care provider were over 2.5 times more likely to be interested in using it (Fleming, Sokoloff, & Raine, 2010).

Family planning clinics rely heavily on the expertise of advanced practitioners such as nurse practitioners and certified nurse midwives (K. Burke, personal communication, May 9, 2011). Nonetheless, research is sparse in investigating their experiences with EC provision and copper IUD insertion. Provider willingness to offer the copper IUD as a form of EC, and the barriers they face in doing so, must be further explored. An ongoing prospective clinical trial is investigating the use of same-day insertion of the copper IUD among women presenting at family planning clinics for EC in Salt Lake City. Early results indicate that advanced practice clinicians experience high rates of IUD insertion failure, meaning the IUD was not successfully placed and the participant was not given her preferred method of EC. This finding suggests that a woman's ability to avoid unintended pregnancy through use of a long-term method of contraception may be attributed to factors out of her control.

The Influence of Male Partners

Contraceptive method choice and use is often initially perceived as a joint male and female responsibility. Data from the National Survey of Men reveals that 78% of men in heterosexual relationships hold egalitarian views on contraception decision-making (Grady, Tanfer, Billy & Lincoln-Hanson, 1996). Although they posit that survey responses may reflect ideology more than behaviors, the authors note that a woman's partner nevertheless greatly influences contraceptive behavior while contraception-related policies and programs continue to exclude men. Males frequently overestimate their reproductive health and sexuality knowledge, further emphasizing the need for male-friendly health services (Makenzius, Gåden, Tydén, Romild & Larsson, 2009). Men may want to increase involvement in contraceptive use and decision-making, yet policies and healthcare providers alleviate them from responsibility by focusing programs and services on women (Ringheim, 1996).

Currently, there is little medical or social work research investigating males' conceptualization of EC and experiences accessing it, limiting policymakers and practitioners' ability to increase male involvement with EC. Research appears to be restricted to males' experiences and perceptions of EC pills rather than the copper IUD as a form of EC. A recent study investigating the perceptions and barriers of male access to EC reports that 78% of both male and female respondents believe men should always be able to purchase EC. However, 50% of male respondents did not know where to obtain EC, and approximately 20% of males were unaware of EC (Nguyen & Zaller, 2009). Studies reporting EC discussions between patients and healthcare providers are limited to conversations with female patients (Corbett, Mitchell, Taylor, & Kemppainen, 2005;

Vahratian, Patel, Wolff & Xu, 2008; Lawrence, Rasinski, Yoon & Curlin, 2010). These results suggest that while males may be interested in accessing it, EC continues to be viewed as a female issue.

The nature and personal definition of specific sexual relationships may further influence a couples' contraceptive use. A woman's pregnancy intentions and behaviors differ by partner, and the nature of a current relationship significantly affects her pregnancy intention (Zabin, Huggins, Emerson & Cullins, 2000). A longitudinal study on the associations between low-income women's relationship characteristics and contraceptive use suggests that women in more established relationships might be less motivated to avoid pregnancy, and consequently be less likely to use a contraceptive method (Wilson & Koo, 2008). Conversely, research also demonstrates that women in casual relationships may also be limited in effective contraceptive use as little to no method discussion occurs between partners (Raine et al., 2010). Thus the current literature is unclear on the exact effect of a woman's sexual relationships on her contraceptive behaviors.

Relevance to Social Work

Unintended pregnancy presents significant economic and psychological consequences for women during their reproductive years. Although methods exist to help reduce the risk of an unintended pregnancy, numerous barriers persist to EC obtainment. The primary goals of the social work profession are to improve the general wellbeing of individuals, and to ensure that basic human needs are met for all people. These goals are achieved through collaborative work promoting social justice and change

at the individual, familial, organizational, and community levels (National Association of Social Workers Code of Ethics, 1996). This dissertation is aimed at improving the circumstances of individuals at risk of unintended pregnancy by increasing our understanding of how EC is experienced and perceived by women, men, and healthcare providers.

Ecological Systems Theory

Ecological Systems Theory (EST) will be used to explore experiences with EC use in this dissertation. EST posits that throughout an individual's life course, his/her development, and consequently his/her behavior, is shaped through processes of bi-directional interaction between the individual and his/her environments (Bronfenbrenner, 1979). Progressively more complex interactions and processes occur between the individual and the people, objects, symbols, and systems in his/her immediate environments throughout the life course. These processes may result in competence, which is defined as the ability to conduct and direct one's behaviors across situations and different domains. Alternatively, processes may lead to dysfunction, or difficulty in sustaining control and successful behavioral integration across situations and domains (Bronfenbrenner & Morris, 1998). Understanding the influences of a woman's environment on her experiences with and perceptions of EC can result in enhancing her ability to navigate across situations and sustain control over her pregnancy intentions.

Throughout EST's progression and evolution, three concepts remain at its core. First, EST situates the active person at the center of the theory, and emphasizes his/her role in the developmental process not only through reacting and responding to his/her

environments, but in shaping his/her environments in turn. Second, an underlying tenet of EST is its phenomenological nature, and the consequent necessity of understanding a person through the meanings they make from individual experience. Third, people will respond to an environment differently. Therefore, individual experiences and environmental influences are context-specific (Darling, 2007).

The process-person-context model highlights the joint functions of the characteristics of both the individual and those of the environments that are either favorable or adverse to development (Bronfenbrenner, 1992). Our environments are organized into four levels of systems: the micro, meso, exo, and macro systems. The micro-system comprises the roles, activities, and interpersonal relations that an individual experiences within a particular face-to-face setting. A micro-system further contains the belief systems of other individuals within the setting. Belief systems are defined and bound by the particular culture an individual lives within; thus these systems vary over time and location. Belief systems are built and influenced by the socialization done with peers, sexual partners and healthcare providers, and further define the ways through which an individual will interact with others. Male sexual partner perceptions about EC and their roles in accessing it as well as the training and attitudes of healthcare providers around EC will influence a woman and her views and utilization of EC.

The meso-system is a system of micro-systems, which consist of connections and processes occurring between two or more settings. A meso-system exists when an individual engages in behaviors or activities in more than one setting. The EC perceptions of a woman's peers and what she is taught in her school will impact how she views EC.

The exo-system includes the relationships and processes occurring between two or more meso-systems. However, at least one system will not ordinarily contain the individual, yet will include events that will influence the individual within his/her immediate settings. For example, the relationship between the values around contraception, sexual behavior, and expected gender roles within a sexual partner's family, and the relationship between the sexual partner and a woman may be considered an exo-system influence on her perceptions on EC.

Finally, macro-systems refer to the consistency observed within a given culture or subculture in the form and content of micro, meso, and exosystems, as well as any belief systems underlying such consistencies (Bronfenbrenner, 1979). Consistency is referred to as patterns that operate on organization and behavior supporting values held by members of a given culture or subculture. For instance, the way that individuals and conscience clauses within the healthcare system stigmatize the need for EC, as well as the women who access it, may be a macro-system influence on a woman who is contemplating the use of EC. Additionally, the underlying beliefs apparent in policy and programs aimed at reducing unintended pregnancy perpetuate a societal value that EC is not only a woman's issue but one also in need of moral intervention.

EST attempts to explain how different levels of environments influence an individual, and how individuals will respond differently to their environments. The interactions between a woman and her environments must be examined to understand her behaviors related to EC, and her ability to control those behaviors. This theory can add insight into how a woman's environment, perceptions of her environment, and the

experiences and belief systems of others within her environments impact and influence unintended pregnancy.

Research Questions

This dissertation will address the following research questions through three qualitative studies:

1. What influences women's decisions about using oral EC or the copper IUD as a form of EC?
2. What are the experiences of Advanced Practitioners with inserting the copper IUD as a form of EC at family planning clinics?
3. Among heterosexually active men, what are their experiences with and perceptions about EC pills and the copper IUD?

Methodology

Qualitative research methods were utilized to address these three research questions. Qualitative methods are emergent, naturalistic and interpretive approaches to investigate processes and the socially constructed nature of reality. Furthermore, qualitative research methods allow for the examination of the complex social interactions occurring within an individual's social world and the meanings assigned to those experiences (Denzin & Lincoln, 2005). Qualitative research is situated within the social, political, and cultural settings of the participants and researcher, thus allowing for understanding of study findings within these specific contexts (Creswell, 2007). Current research has not investigated the factors influencing a woman's choice of EC method, the

experiences of healthcare practitioners with inserting the copper IUD as a form of EC, or the experiences of men with EC and the meanings they assign to these experiences. This dissertation will allow for deeper understanding into the failure of EC to reduce the rates of unintended pregnancy in the United States.

Research Paradigm

A paradigm is defined as a basic set of philosophical assumptions used to guide research and understand social behavior. It addresses approaches to ontology, epistemology, methodology, ethics, and participants (Guba & Lincoln, 2005; Rubin & Babbie, 2008). A constructivist-interpretivist paradigm was applied to frame the three proposed studies. Constructivism-interpretivism posits that there are multiple, subjective realities, and each participant constructs, or interprets, an individual reality within their specific historical and social context. Therefore, the goal of this type of research is to understand the lived experiences from an individual's viewpoint as the researcher and participant co-construct the meaning from the questions asked and the responses elicited (Ponterotto, 2005).

Subjectivity and Reflexivity

Qualitative researchers assert that the very nature of data gathering and analysis are subjective (Morrow, 2005). While not intended to eliminate subjectivity, multiple methods will be applied to manage it. Member-checking occurred throughout the interview and focus group process to ensure accurate interpretation of participant responses. Participants were invited to review transcripts, preliminary themes, and

provide feedback on initial interpretation of findings. Within qualitative research, the researcher is an instrument and must consequently be aware of personal views and beliefs related the research topic. I am a White, heterosexual woman and mother operating within an academic setting. These identities each influence the lens through which I approached the research topic, framed interview questions and interpreted data, as well as how research participants viewed and responded to me. Reflexivity, or the process of maintaining awareness of personal assumptions and biases related to the research topic and participants, actively occurred throughout data collection and analysis (Morrow, 2005). I journaled immediate reactions and thoughts following individual interviews (Study 1) and focus groups (Studies 2 and 3). A peer research team comprised of social work doctoral students was consulted during data analysis phases for each study.

Participant Selection and Data Management

Purposeful, criterion selection was utilized in participant recruitment to address each research question. Participants were selected based on their ability to speak to the experience under study rather than to provide a randomized or generalizable sample (Polkinghorne, 2005). Interviews and focus groups were audio-recorded and transcribed. Transcribed interviews from each study were analyzed with HyperRESEARCH, a qualitative analysis software program. HyperRESEARCH enables the coding, theory building, and data analysis of both audio and word files. It also allows multiple research team members to exchange study files and sources.

Ethical Considerations

Approval was obtained from the University of Utah IRB for each study. A Federal Wide Assurance (FWA) allows the University of Utah IRB to approve studies conducted by University personnel conducted at Planned Parenthood Association of Utah (PPAU) clinics, as was the case for Studies 1 and 2. Informed consent was obtained from each research participant. Emphasis was placed on confidentiality, and HIPAA and IRB guidelines were followed to ensure adequate protection of participant information. All identifying information was removed from interview and focus group transcripts, and participant names and demographic data are stored on a password-protected computer. Due to the structure of focus groups, participants share information not only with the researcher, but with all other group members as well (Morgan, 1997). Therefore, focus group participants were instructed to maintain confidentiality outside of the group interaction to protect the privacy of each participant.

Study 1 (Chapter 2)

Participant Selection Procedures

To investigate the first research question (what influences women's decisions about using oral EC or the copper IUD as a form of EC?), participants enrolled in a prospective clinical trial investigating the use of oral EC versus the copper IUD were recruited for the qualitative portion of the larger study. This prospective clinical trial enrolled women seeking EC at two PPAU clinics in the Salt Lake City area. Participants selected either oral EC or the copper IUD as a method of EC.

All participants were invited to complete an individual interview, and up to three attempts were made to schedule interviews with interested women. Participants were women aged 18-30 presenting at two family planning clinics in Salt Lake City, Utah, and who had engaged in unprotected sexual intercourse within the last 120 hours.

Data Gathering and Analysis

A PPAU staff member and I conducted individual interviews at one family planning clinic involved with a larger clinical trial. Interview questions inquired about contraceptive method knowledge, longterm contraceptive consideration, and previous experiences with EC. Semistructured individual interviews were completed with 14 IUD users and 14 oral EC users. Recruitment continued until saturation and even numbers of IUD and oral EC users were interviewed. Please refer to Appendix A for the interview schedule. Supplementary data, such as reason for EC and previous pregnancies, were also gathered from participant intake files. The interviewers met after each interview to discuss initial impressions. Interviews were audio-recorded, transcribed, and independently analyzed by two investigators. Transcripts were read and reread, and categories and themes were identified and coded (Marshall & Rossman, 2006). Line by line analysis was also conducted on large portions of data to gain a fuller and deeper understanding of the interview data (Charmaz, 2006).

Timeframe and Publication

Recruitment began in late November 2009 and concluded in June 2010. Analysis of interview data was concurrent with data collection, which continued until redundancy

and saturation were achieved. A manuscript was submitted in December 2010 and accepted for publication in April to the January 2012 issue of *Contraception,* a journal aimed at the rapid dissemination of contraceptive research findings.

Study 2 (Chapter 3)

Participant Selection Procedures

To address the second research question, (what are the experiences of Advanced Practitioners with inserting the copper IUD as a form of EC at family planning clinics?), potential participants were recruited through quarterly staff meetings at PPAU clinics in the Salt Lake City area and from a national conference for reproductive healthcare providers. Announcements were made in staff meetings, and an email was distributed with a study description and focus group dates. Participants are Advanced Practice (AP) clinicians who have inserted the copper IUD as a method of EC. Recruitment was limited to providers with work experience at Planned Parenthood clinics in order to achieve typical case sampling (Patton, 2002).

Data Gathering and Analysis

Interested APs were invited to participate in an individual interview or a focus group comprised of 5-8 individuals with a target of 3-5 focus groups. The purpose of a self-contained focus group is to efficiently gather a large amount of qualitative data when the research interest is placed upon not only what participants think about the topic, but also how and why they think the ways they do (Krueger & Casey, 2000; Morgan, 1997). Focus group methods allow additional insight into understanding individual differences

and perspectives through group discussion and interaction (Krueger & Casey, 2000). Interested practitioners were also offered alternative participation in an individual interview. A general overview of the research area and purpose of the study was introduced at the beginning of interviews and focus groups.

Focus groups and individual interviews were held at PPAU clinics or at a location of the participant's choosing and lasted approximately 45 minutes. Please refer to Appendix B for the focus group questions. I conducted individual interviews. If focused groups would have taken place, I would have moderated the focus group discussion and a peer-researcher served as a note-taker. Interviews were audio recorded and transcribed.

This study employed a phenomenological approach to data gathering and analysis. Phenomenology is the examination of the lived experiences and meanings individuals create of a particular phenomenon (Creswell, 2007). Phenomenology is concerned with intentionality, or the orientation of the mind to the phenomenon and the internal process of being conscious of it. Intentionality is composed of textural (perception of the phenomenon) and structural (experience with the phenomenon) dimensions, and the relationships between them. Phenomenological studies investigate the phenomenon through providing descriptions of thoughts, feelings, and ideas constituting one's experience rather than providing explanations of the experience (Moustakas, 1994).

An important component in phenomenology is Epoche (Moustakas, 1994), wherein the researcher consciously sets aside personal understandings, experiences, and judgments related to the phenomenon. Epoche occurs throughout the research process,

and allows for an open and naïve approach to the phenomenon under study. As a component of Epoche, a peer interviewed me utilizing the focus group questions prior to study commencement. This practice allows for the researcher to gain further awareness of personal biases and views related to the research topic, and to bracket these biases during the research process in order to minimize subjective interpretations of the findings.

Analysis occurred through horizonalizing of the data, through which each statement relevant to the study focus is given equal value, and each expression or meaning unit derived from the transcripts were listed. Meaning units were then clustered into common themes used to develop first the textural then structural depictions of participant experiences. The study resulted in a thematic presentation of the phenomenon through interweaving the fundamental textural and structural descriptions (Moustakas, 1994).

Timeframe and Publication

Recruitment and data gathering began July 2011. Participants were invited to complete an interview or focus group until the target of 12 interviews or 3-5 groups comprised of 5-8 participants was reached. Analysis was concurrent with data gathering, and was completed in January 2012. A manuscript was prepared for submission to the *Journal of Midwifery & Women's Health*, an interdisciplinary journal aimed at publishing research addressing topics within women's heath, policy, public health, and midwifery.

Study 3 (Chapter 4)

Participant Selection Procedures

To address the third research question (Among heterosexually active men, what are their experiences with and perceptions about EC?), participants were recruited through master and bachelor level courses in the College of Social Work at the University of Utah. IRB-approved fliers advertising the research project were placed in the college lobbies. Announcements were also made in BSW and MSW research, policy, and practice classes. Potential participants were limited to heterosexually active men aged 18-40 able to engage in a focus or small group discussion in English. Snowball sampling was utilized with the initial research participants to increase the number of potential participants. Interested individuals were given my contact information and focus group dates, times and locations.

Data Gathering and Analysis

Focus groups were conducted at the College of Social Work and were co-facilitated by a male moderator. It is suggested that gender role socialization may lead to difficulties in expressing feelings and thoughts among males (Norwinski, 1993). Due to male socialization around contraception, a male facilitator may be more appropriate than a female-only facilitator in assisting men to elicit their feelings, beliefs, and perceptions regarding EC.

Focus groups were selected as the most appropriate method of data collection for this research question. The interactive and process-oriented nature of focus group

interactions allow for participants with limited experience or knowledge on a specific topic to develop perceptions based on responses elicited from other group participants. Further, this method of data collection allows for additional insight into understanding individual differences and perspectives through group discussion and interaction (Krueger & Casey, 2000). Because EC is predominately defined as a female-specific issue, I anticipated that participants have limited experience accessing or discussing EC with female partners and healthcare providers. Please reference Study 2 for further discussion on focus group structure, and to Appendix C for focus group questions.

Similar to Study 2, this study applied a phenomenological approach to data gathering and analysis. Phenomenology is the examination of the lived experiences and meanings individuals create of a particular phenomenon (Creswell, 2007). Phenomenology is concerned with intentionality, or the orientation of the mind to the phenomenon and the internal process of being conscious of it. Males' perceptions of and experiences with EC were explored, and the relationships between the perceptions and experiences. Consistent with phenomenological methodology, this study provided descriptions of participants' thoughts, feelings, and ideas constituting their experiences instead of attempting to explain their experiences. (Moustakas, 1994).

Epoche, the conscious setting aside of personal understandings, experiences, and judgments related to the study, occurred throughout the research process. As a part of Epoche, the male peer moderator interviewed me prior to the study commencement utilizing the focus group questions. Analysis occurred through horizonalizing of the data. Each statement relevant to the study focus was given equal value, and each expression or meaning unit derived from the transcripts was listed. Meaning units were then clustered

into common themes used to develop first the textural then structural depictions of participant experiences. The final results consist of a presentation of the phenomenon through interweaving the fundamental textural and structural descriptions (Moustakas, 1994).

Timeframe and Publication

Recruitment began October 2011 until the target of a minimum of 15 participants was reached. Data analysis was completed by February 2012 and manuscript preparation concluded in March 2012. A manuscript was prepared for submission to *The American Journal of Men's Health*. This publication is dedicated to research addressing men's health from numerous disciplines including public health, the social sciences, and social work.

References

ACOG Committee Opinion (2009). Increasing uses of contraceptive implants and intrauterine devices to reduce unintended pregnancy. *Obstetrics & Gynecology, 114*(6), 1434-1438.

Ayoola, A.B., Nettleman, M., & Brewer, J. (2007). Reasons for unprotected intercourse in adult women. *Journal of Women's Health, 16*(3), 302-310. Doi: 10.1089/jwh.2007.0210

Baydar, N. (1995). Consequences for children of their birth planning status. *Family Planning Perspectives, 27*(6), 228-234.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. (1992). Ecological systems theory. In R. Vasta (Ed.), *Six Theories of Child Development: Revised Formulations and Current Issues* (pp. 187-249). London: Jessica Kingsley Publishers.

Bronfenbrenner, U., & Morris, P.A. (1998). The ecology of developmental processes. In R.M. Lerner (Ed.), *Handbook of Child Psychology* (5th ed., pp. 993-1028). New York: Wiley.

Brown, S.S., & Eisenberg, L. (1995). *The best intentions: Unintended pregnancy and well-being of children and families.* Washington, DC: National Academy Press.

Campo, S., Askelson, N.M., Spies, E.L., & Losch, M. (2010). Preventing unintended pregnancies and improving contraceptive use among young adult women in a rural, Midwestern state: Health promotion implications. *Women & Health, 50*(3), 279-296. Doi: 10.1080/03630242.2010.480909

Charmaz, K. (2007). *Constructing grounded theory: A practical guide through qualitative analysis.* Thousand Oaks, CA: Sage.

Corbett, P.O., Mitchell, C.P., Taylor, J.S., & Kemppainen, J. (2006). Emergency contraception: Knowledge and perceptions in a university population. *Journal of the American Academy of Nurse Practitioners, 18,* 161-168. Doi: 10.1111/j.1745-7599.2006.00114x

Creswell, J.W. (2007*). Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Culwell, K.R., & Feinglass, J. (2007). The association if health insurance with use of prescription contraceptives. *Perspectives on Sexual and Reproductive Health, 39*(4), 226-230. Doi: 10.1363/3922607

Darling, N. (2007). Ecological systems theory: The person in the center of the circles. *Research in Human Development, 4*(3-4), 203-217. Doi: 10.1080/15427600701663023

Dehlendorf, C., Levy, K., Ruskin, R., & Steinauer, J. (2010). Health care providers' knowledge about contraceptive evidence: A barrier to quality family planning care? *Contraception, 81,* 292-298. Doi: 10.1016/j.contraception.2009.11.006

Denzin, N.K., & Lincoln, Y.S. (2005). The discipline and practice of qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* (3rd ed., pp. 1-41). Thousand Oaks, CA: Sage.

Doyle, J., Stern, L., Hagan, M., Hao, J., & Gricar, J. (2008). Advances in contraception: IUDs from a managed care perspective. *Journal of Women's Health, 17*(6), 987-992. Doi: 10.1089/jwh.2008.0814

Fagan, E.B., Boussios, H.E., Moore, R., & Galvin, S.L. (2006). Knowledge, attitudes, and use of emergency contraception among rural western North Carolina women. *Southern Medical Journal, 99*(8), 806-810.

Finer, L.B., & Henshaw, S.K. (2006). Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual & Reproductive Health, 38*(2), 90-96.

Fleming, K.L., Sokoloff, A., & Raine, T.R. (2010). Attitudes and beliefs about the intrauterine device among teenagers and young women. *Contraception, 82,* 178-182. Doi: 10.1016/j.contraception.2010.02.020

Foster, D.G., Bley, J., Mikanda, J., Induni, M., Arons, A., Baumrind, N., Darney, P.D., & Stewart, F. (2004). Contraceptive use and risk of unintended pregnancy in California. *Contraception, 70*(1), 31-39.

Gipson, J.D., Koening, M.A., & Hindin, M.J. (2008). The effects of unintended pregnancy on infant, child, and parental health: A review of the literature. *Studies in Family Planning, 39*(1), 18-38.

Glei, D.A. (1999). Measuring contraceptive use patterns among teenage and adult women. *Family Planning Perspectives, 31*, 73-80.

Goodwin, M.M., Gazmararian, J.A., Johnson, C.H., Gilbert, B.C., Saltzman, & the PRAMS Working Group. (2000). Pregnancy intendedness and physical abuse

around the time of pregnancy: Findings from the Pregnancy Risk Assessment Monitoring System, 1996-1997. *Maternal & Child Health Journal, 4*(2), 85-92.

Grady, W.R., Tanfer, K., Billy, J.O.G., & Lincoln-Hanson, J. (1996). Men's perceptions of their roles and responsibilities regarding sex, contraception and childrearing. *Family Planning Perspectives, 28*(5), 221-226.

Guba, G.G., & Lincoln, Y.S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N.K. Denzin & Y.S. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* (3rd ed., pp. 191-216). Thousand Oaks, CA: Sage.

Hickey, M.T. (2009). Female college students' knowledge, perceptions, and use of emergency contraception. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 38,* 399-405. Doi: 10.1111/j.1552-6909.2009.01035x

Hellerstedt, W.L., Pirie, P.L., Lando, H.A., Curry, S.J., McBride, C.M., Grothaus, L.C., & Nelson, J.C. (1998). Differences in preconceptional and prenatal behaviors in women with intended and unintended pregnancies. *American Journal of Public Health, 88*(4), 663-666.

Homco, J. B., Peipert, J. F., Secura, G. M., Lewis, V. A., & Allsworth, J. E., (2009). Reasons for ineffective pre-pregnancy contraception use in patients seeking abortion services. *Contraception, 80,* 569-574.

Jones, R.K., & Kavanaugh, M.L. (2011). Changes in abortion rates between 2000 and 2008 and lifetime incidence of abortion. *Obstetrics & Gynecology, 117*(6), 1358-1366. Doi: 10.1097/AOG.0b013e3182c405e

Kramer, M. R., Rowland Hogue, C. J., & Gaydos, L. M. D., (2007). Noncontracepting behavior in women at risk for unintended pregnancy: What's religion got to do with it? *AEP, 17*(5), 327-334.

Krueger, R.A., & Casey, M.A. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage.

Lakha, F., & Glasier, A. (2006). Unintended pregnancy and use of emergency contraception among a large cohort of women attending for antenatal care or abortion in Scotland. *Lancet, 368,* 1782-1787.

Lawrence, R.E., Rasinski, K.A., Yoon, J.D., & Curlin, F.A. (2010). Obstetrician-gynecologist physicians' beliefs about emergency contraception: A national survey. *Contraception, 82,* 324-330. Doi: 10.1016/j.contraception.2010.04.151

Makenzius, M., Gåden, K.G., Tydén, T., Romild, U., & Larsson, M. (2009). Male students' behaviour, knowledge, attitudes, ad needs in sexual and reproductive health matters. *The European Journal of Contraception & Reproductive Health Care, 14*(4), 268-276.

Marshall, C., & Rossman, G.B. (2006). *Designing Qualitative Research.* Thousand Oaks, CA: Sage.

Mills, A., & Barclay, L. (2006). None of them were satisfactory: Women's experiences with contraception. *Health Car for Women International, 27,* 379-398.

Morgan, D.L. (1997). *Focus groups as qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Morrow, S.L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250-260. Doi: 10.1037/0022-0167.52.2.250

Moss, E., Reynolds, T., & Kundu, A. (2009). Emergency contraception: Patterns of use in community sexual health clinics. *Journal of Obstetrics & Gynaecology, 29*(4), 337-339. Doi: 10.1080/01443610902862712

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Norwinski, J.(1993). *Hungry hearts: On men, intimacy, self-esteem, and addiction.* New York: Lexington Books.

Nguyen, B.T., & Zaller, N. (2009). Male access to over-the-counter emergency contraception: A survey of acceptability and barriers in Providence, Rhode Island. *Women's Health Issues, 19,* 365-372. Doi: 10.1016/j.whi.2009.07.003

Patton, M.Q. (2002). *Qualitative evaluation and research methods.* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Polkinghorne, D.E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology, 52*(2), 137-145. 10.1037/0022-0167.52.2.137

Ponterotto, J.G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52*(2), 126-136. Doi: 10.1037/0022-0167.52.2.126

Raine, T.R., Gard, J.C., Boyer, C.B., Haider, S., Brown, B.A., Hernandez, F.A.R., & Harper, C.C. (2010). Contraceptive decision-making in sexual relationships:

Young men's experiences, attitudes, and values. *Culture, Health & Sexuality, 12*(4), 373-386. Doi: 10.1080/13691050903524769

Raymond, E.G., Trussell, J., & Polis, C.B. (2007). Population effect of increased access to emergency contraceptive pills. *Obstetrics & Gynecology, 109*(1), 181-188.

Ringheim, K. (1996). Whither methods for men? Emerging gender issues in contraception. *Reproductive Health Matters, 4*(7), 79-89.

Rubin, A., & Babbie, E.R. (2008). *Research methods for social work* (6th ed.). Belmont, CA: Thomson Brooks/Cole.

Schwarz, E.B., Kavanaugh, M., Douglas, E., Dubowitz, T., & Creinin, M.D. (2009). Interest in intrauterine contraception among seekers of emergency contraception and pregnancy testing. *Obstetrics & Gynecology, 113*(4), 833-839.

Shlay, J.C., Zolot, L., Bell, D., Maravi, M., & Urbina, C. (2009). Associations between provisions of initial family planning services and unintended pregnancy among women attending an STD clinic. *Journal of Women's Health, 18*(10), 1693-1699. Doi: 10.1089/jwh.2008.0966

Sonfield, A., Kost, K., Gold, R.B., & Finer, L.B. (2011). The public costs of births resulting from unintended pregnancies: National and state-level estimates. *Perspectives on Sexual and Reproductive Health, 43*(2), 94-102. Doi: 10.1363/4309411

Trussell, J., Ellerston, C., Stewart, F., Raymond, E.G., & Shochet, T. (2004). The role of emergency contraception. *American Journal of Obstetrics & Gynecology, 190,* S30-38. Doi: 10.1016/j.ajog.2004.01.063

Trussell, J., Koenig, J., Ellertson, C., & Stewart, F. (1997). Preventing unintended pregnancy: The cost-effectiveness of three methods of emergency contraception. *American Journal of Public Health, 87*(6), 932-937.

Vahratian, A., Patel, D.A., Wolff, K., & Xu, X. (2008). College students' perceptions of emergency contraception provision. *Journal of Women's Health, 17*(1), 103-111. Doi: 10.1089/jwh/2007.0391

Vaughan, B., Trussell, J., Kost, K., Singh, S., & Jones, R. (2008). Discontinuation and resumption of contraceptive use: Results from the 2002 National Survey of Family Growth. *Contraception, 78*, 271-283. Doi: 10.1016/j.contraception.2008.05.007

Williamson, L.M., Buston, K., & Sweeting, H. (2009). Young women's perceptions of pregnancy risk and use of emergency contraception: Findings from a qualitative study. *Contraception, 79,* 310-315. Doi: 10.1016/j.contraception.2008.10.014

Wilson, E.K., & Koo, H.P. (2008). Associations between low-income women's relationship characteristics and their contraceptive use. *Perspectives on Sexual and Reproductive Health, 40*(3), 171-179.

Wright, R., Frost, C., & Turok, D. (2012). A qualitative exploration of emergency contraceptive users' willingness to select the copper IUD. *Contraception, 85*(1), 32-35.

Xaverius, P.K., Tenkku, L.E., & Salas, J. (2009). Differences between women at higher and lower risk for an unintended pregnancy. *Women's Health Issues, 19,* 306-312. Doi: 10.1016/j.whi.2009.06.002

Zabin, L.S., Huggins, G.R, Emerson, M.R., & Cullins, V.E. (2000). Partner effect on a woman's intention to conceive: 'Not with this partner'. *Family Planning Perspectives, 32*(1), 39-45.

CHAPTER 2

A QUALITATIVE EXPLORATION OF EMERGENCY CONTRACEPTIVE USERS' WILLINGNESS TO SELECT THE COPPER IUD

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A qualitative exploration of emergency contraception users' willingness to select the copper IUD

Rachel L. Wright[a,*], Caren J. Frost[a], David K. Turok[b]

[a]College of Social Work, University of Utah, Salt Lake City, UT 84112, USA
[b]Department of Obstetrics and Gynecology, University of Utah, Salt Lake City, UT 84132, USA

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Abstract

Background: The copper T intrauterine device (IUD) is an effective but underutilized method of emergency contraception (EC). This study investigates the factors influencing a woman's decision around which method of EC to select.
Study Design: In-depth interviews with 14 IUD and 14 oral EC users aged 18–30 years accessing public health clinics.
Results: Emergency contraception users associated long-term methods of contraception with long-term sexual relationships. Women were not aware of the possibility of using the copper IUD for EC. Cost was identified as a major barrier to accessing IUDs. Perceived side effects and impact on future pregnancies further influenced the EC method a participant selected.
Conclusions: Women think about contraception in the context of each separate relationship and not as a long-term individual plan. Most women were unaware of the copper IUD for EC. Furthermore, there is little discussion between women and their health-care providers around EC.

Keywords: Emergency contraception; IUD; Women; Decision-making; Qualitative methods

1. Introduction

The unintended pregnancy rate in the United States is the highest among developed countries. An estimated 30% of women aged 15–44 years will have an unintended birth, and the rate is even higher among women living at or below the poverty level [1]. The wide availability of oral emergency contraception (EC) has not reduced unplanned pregnancy or abortion rates [2]. Although the copper T intrauterine device (IUD) is a highly effective method of EC, knowledge and use among women in the United States remain low [3,4].

There is little literature investigating women's willingness to use the copper IUD as a method of EC and what factors might influence their decision-making process. Qualitative research methods are an effective approach for developing a comprehensive understanding about how women conceptualize issues around EC and unintended pregnancy. This approach allows for a broader awareness of women's contraceptive decision-making process within their social context [5]. This study investigated what factors influence women's decisions about using the copper IUD as a form of EC.

2. Methods

Participants enrolled in a prospective clinical trial about the use of the copper IUD vs. oral levonorgestrel EC were offered participation in a qualitative component. The larger clinical trial enrolled women aged 18–30 years presenting for EC within 120 h of unprotected intercourse at family planning clinics in Salt Lake City, UT. At trial enrollment for the larger study, participants were queried regarding willingness to participate in the qualitative study involving individual, in-depth interviews. Up to three attempts were made to contact each interested individual to schedule an interview or participation in a focus group. Individual interviews were conducted at one of the family planning clinics where the study was conducted. Interview questions inquired about knowledge of contraceptive methods, long-term contraceptive consideration and past experiences with EC.

Interviews were audio-recorded, transcribed and independently analyzed by two investigators (C.J.F. and R.L.W.).

* Corresponding author. Tel.: +1 801 215-9015; fax: +1 801 585 3212.
E-mail address: rachel.lee.wright@gmail.com (R.L. Wright).

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Interviews were read and reread, and categories and themes were identified and coded [6]. Line-by-line analysis was also conducted on large paragraphs of data to gain a fuller understanding about the interview information [7]. The researchers collected data until information saturation was achieved. Study staff were prepared to conduct interviews in English and Spanish. Approval was obtained from the University of Utah Institutional Review Board.

3. Results

Participants were selected to create equal groups of copper IUD and oral EC users. Semistructured individual interviews (lasting on average 45 min) were conducted with 14 copper IUD users and 14 oral EC users. All interviews were conducted in English. Researchers were not able to schedule any focus groups with a sufficient number of participants. There were no significant differences in demographic data between participants who were interviewed and those who failed to attend scheduled interviews.

Demographic and descriptive characteristics about study participants are displayed in Table 1. Of the 14 oral EC users, two initially selected the copper IUD as their preferred method of EC; however, they received oral EC due to the practitioners' inability to insert the copper IUD. The remaining 12 women in this group initially selected oral EC. Half of oral EC and 21% of copper IUD users had no previous experience with EC, while 21% of oral EC and 35% of copper IUD participants used EC four or more times prior to the study. Please refer to Table 2 for participant reason for EC use.

Three major themes emerged from the interview data: long-term methods associated with long-term relationships, contraceptive cost and knowledge, side effects and pregnancy considerations. These themes are explored below.

Table 1
Participant demographics

Variable	IUD	Oral EC
Age (years), mean (SD)	22.4 (2.9)	22.7 (3.8)
Race/ethnicity, *n* (%)		
White	12 (85.7)	10 (71.4)
Pacific Islander	2 (14.3)	0
Latina	0	4 (28.6)
Income ($), *n* (%)		
<20,000	12 (85.7)	10 (71.4)
20–40,000	2 (14.3)	2 (14.3)
40–80,000	0	2 (14.4)
Number of previous times used EC, *n* (%)		
0	3 (21.4)	7 (50)
1–3	4 (28.6)	3 (21.4)
4 or more	5 (35.7)	3 (21.4)
Not specified	2 (14.3)	1 (7.1)
Insurance coverage for BC, *n* (%)		
Yes	5 (35.7)	4 (28.6)
No	1 (7.1)	1 (7.1)
Do not know	3 (21.4)	4 (28.6)
No insurance	5 (35.7)	5 (35.7)

Table 2
Reason for EC

	IUD	Oral EC
No birth control refill	6	0
Missed pills	1	1
No method used	3	9
Condom broke/slipped	3	2
Withdrawal method failed	1	2

3.1. Long-term methods associated with long-term relationships

The type of EC participants selected related to their relationship status. Women who identified as being in a long-term relationship were more likely to select the copper IUD as a form of EC due to its ability to act as a long-term contraceptive method. Women not currently engaged in a long-term relationship did not identify long-term contraception as necessary due to either infrequent sexual activity or the perception that their short-term relationship did not warrant the effort of investigating long-term options.

> It is just based on where you are in life too I guess, and like if you don't know, if you are like in a serious relationship you probably want a more serious form of birth control, but if you are not, you probably won't go to a lot of measures to figure out what there is and you will stick with condoms (#1, copper IUD).

> When I first started this [study], you know they said you could either do the IUD or the Plan B [oral levonorgestrel] the day you come in, I was really tempted to do the IUD, I think it is also, I am not really in a relationship right now so there is not really a point to do that (#1, oral EC).

3.2. Cost

The cost of a method emerged as a significant factor in women's decision-making process. While participants may have had prior interest in IUDs as a form of birth control, the high upfront cost was presented as a substantial barrier. Frequently, the cost of a copper IUD prevented further investigation into its possible benefits and risks.

> When I first actually heard about the IUD, I was interested in it, but it was really expensive up front. Over the long run it becomes more cost effective, but people don't think about it that way. (#2, copper IUD).

> I thought about it [IUD] for a really long time, probably like starting couple of years ago even, and what kept me from getting it back then was the cost. So had I been able to afford it, I would have gotten it longer, like earlier (#3, copper IUD).

Oral EC users did not identify the cost of oral levonorgestrel as too high or high enough to prevent access.

Therefore, they expressed comfort with continued reliance on oral EC as either a secondary or main form of contraception.

> Birth control can be pricey and condoms are pricey and so it's kind of a big thing. You don't want to get pregnant, but then you don't want to spend all this money on buying everything so, that's why we usually do the pull-out [method] because of price (#2, oral EC).

3.3. Knowledge, side effects and pregnancy considerations

Although most participants held some knowledge of IUDs as an effective, long-term method of contraception, none had prior knowledge of the copper IUD's ability to function as a form of EC. Therefore, enrollment in the larger EC study served as their initial exposure to the dual role of the copper IUD:

> I did not even know that was possible. I thought it [IUD] was just a long-term protection. I didn't know it could count like kind of for the morning after pill (#4, copper IUD).

The possible side effects of an EC method contributed to a woman's decision about which option to select. Participants with prior experience with oral EC were satisfied with its ability to prevent pregnancy and did not identify experiencing negative immediate or long-term side effects with this option. Fear of the potential side effects of the copper IUD contributed further to a woman's decision to select oral EC:

> I felt like the IUD is kind of scary, like we are going to place it inside you and there are all these risks that may or may not happen and that kind of scared me personally (#3 oral EC).

Participants wanted to prevent, or at minimum delay, pregnancy. How a participant perceived the copper IUD's impact on her ability to become pregnant in the future factored into her decision-making process. Women selecting oral EC often viewed the copper IUD as potentially harmful to her ability to become pregnant in the future:

> Yeah but it [IUD] kind of freaked me out because they said when you take it out it could take up to a year to get pregnant, like up to a year to get pregnant (#4, oral EC).

> I didn't want to do anything that would affect having a baby in the future (#5, oral EC).

Conversely, women selecting the copper IUD viewed it as a long-term method with no long-term effects on pregnancy:

> With the IUD you can still take it out whenever you want and get pregnant right away, so it's long-term but it's still really flexible. You know, you can change your mind really easily (#5, copper IUD).

4. Discussion

In this study, while no single factor determined a woman's choice of EC method, our findings reveal that multiple factors contribute to a woman's decision-making process. Women presenting for EC may not be aware of the role of the copper IUD as EC method. Once informed, they have to incorporate this into their decision about which method to select. In our study, some of the factors that influence EC method choice include relationship status, cost and concern about side effects. These factors are consistent with a study of women accessing abortion services who reported the most frequent barriers to contraceptive use include worry about side effects and cost [8].

Couples in casual sexual relationships may be less likely than those in more stable or long-term relationships to be prepared for sexual activity and therefore may not have a preconsidered contraceptive method [9]. The association of long-term contraceptive methods with long-term relationships is troubling. How a woman defines her desire for pregnancy as either wanted or not and her subsequent actions are significantly affected by perceived partner support and relationship longevity [10]. By rejecting long-term effective contraceptive methods, women in casual relationships are more likely to experience unintended pregnancy without partner support and relationship stability.

Although not identified as a major theme, most participants did not identify their health-care providers as primary sources of information on EC in general or of the copper IUD as a form of EC. Furthermore, several nulliparous participants identified their health-care providers as a barrier to obtaining an IUD due to their unwillingness to insert an IUD. While such barriers as the lack of health insurance coverage certainly prevent numerous women from accessing reliable forms of contraception, inaccurate information from health-care providers may further inhibit adequate access to EC. Findings from a study investigating contraception knowledge suggest that a significant level of misinformation persists among health-care providers [11]. A recent Kaiser Family Foundation study on EC reports that few women have discussed any form of EC with their health-care providers [12]. These findings suggest the need for increased discussion about EC between providers and patients.

While no participant identified pregnancy as a current or short-term goal, the ability to become pregnant in the future weighed heavily on participants' interpretation of the benefits and risks of both the copper IUD and oral EC. Participants possessing less knowledge of the copper IUD could not identify a justification for selecting this long-term method of contraception when presenting at clinics for EC. Participants selecting oral EC articulated specific reasons for selecting this method of EC. Our findings support previous research indicating a disconnect between the desire to avoid pregnancy and acceptance of a long-term or consistent contraceptive method [13,14].

Policy-maker and practitioner perspectives may favor the long-term benefits of the copper IUD and its ability to decrease unintended pregnancy. However, oral EC continues to be the preferred EC option for many women. This reasoning is due in part to the timing of future pregnancy,

concern regarding side effects and lack of accurate IUD knowledge. Research indicates that increased knowledge of the IUD leads to more positive attitudes and willingness to utilize the IUD [15]. While it has many benefits, the copper IUD is primarily viewed as a long-term contraceptive method and not as a form of EC. Increased education and discussion both with women and health-care providers may increase familiarity and comfort with the IUD as a form of EC.

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References

[1] Chandra A, Martinez GM, Mosher WD, et al. Fertility, family planning, and reproductive health of U.S. women: data from the 2002 National Survey of Family Growth. Vital Health Stat 2005;23 (25):1–160.

[2] Raymond EG, Trussell J, Polis CB. Population effect of increased access to emergency contraceptive pills: a systematic review. Obstet Gynecol 2007;109:181–8.

[3] Doyle J, Stern L, Hagan M, Hao J, Gricar J. Advances in contraception: IUDs from a managed care perspective. J Womens Health 2008;17:987–92, doi:10.1089/jwh.2008.0814.

[4] Schwarz EB, Kavanaugh M, Douglas E, Dubowitz T, Creinin MD. Interest in intrauterine contraception among seekers of emergency contraception and pregnancy testing. Obstet Gynecol 2009;113:833–9.

[5] Mills A, Barclay L. None of them were satisfactory: women's experiences with contraception. Health Care Women Int 2006;27: 379–98.

[6] Marshall C, Rossman GB. Designing qualitative research. 4th ed. Thousand Oaks (CA): Sage Publications; 2006.

[7] Charmaz K. Constructing grounded theory: a practical guide through qualitative analysis. Thousand Oaks (CA): Sage Publications; 2006.

[8] Homco JB, Peipert JF, Secura GM, Lewis VA, Allsworth JE. Reasons for ineffective pre-pregnancy contraception use in patients seeking abortion services. Contraception 2009;80:569–80, doi:10.1016/j.contraception.2009.05.127.

[9] Glei DA. Measuring contraceptive use patterns among teenage and adult women. Fam Plann Perspect 1999;31:73–80.

[10] Fischer RC, Stanford JB, Jameson P, DeWitt MJ. Exploring the concepts of intended, planned, and wanted pregnancy. J Fam Pract 1999;48:117–22.

[11] Dehlendorf C, Levy K, Ruskin R, Steinauer J. Health care providers' knowledge about contraceptive evidence: a barrier to quality family planning care? Contraception 2010;81:292–8, doi:10.1016/j.contraception.2009.11.006.

[12] Salganicoff A, Wentworth B, Ranji U. Emergency contraception in California: findings from a 2003 Kaiser Family Foundation survey. Menlo Park (CA): The Henry J. Kaiser Family Foundation; 2004.

[13] Sable MR, Libbus MK. Pregnancy intention and pregnancy happiness: are they different? Matern Child Health J 2000;4:191–6.

[14] Gaydos LMD, Hogue CJR, Kramer MR. Riskier than we thought: revised estimates of noncontracepting women risking unintended pregnancy. Public Health Rep 2006;121:155–9.

[15] Whitaker AK, Terplan M, Gold MA, Johnson LM, Creinin MD, Harwood B. Effect of a brief educational intervention on the attitudes of young women toward the intrauterine device. J Pediatr Adolesc Gynecol 2010;23:116–20, doi:10.1016/j.pag.2009.09.012.

CHAPTER 3

EXPERIENCES OF ADVANCED PRACTITIONERS IN INSERTING THE COPPER IUD AS A FORM OF EMERGENCY CONTRACEPTION

Abstract

The rate of unintended pregnancy in the United States remains high. Using emergency contraception (EC) is shown to be highly effective at decreasing unintended pregnancy after unprotected sexual intercourse or experiencing method failure. Most current EC research focuses on oral EC instead of the copper IUD as EC, and no studies have yet explored the experiences of Advanced Practitioners with providing the copper IUD as EC. This qualitative study employs phenomenological methods to explore the experiences of Advanced Practitioners with inserting the copper IUD as EC within family planning clinic settings. The findings provide insights into the experiences of Advanced Practitioners with presenting and inserting the copper IUD with women seeking EC. Recommendations are given for practice, policy, and future research.

Emergency Contraception

Emergency contraception (EC) is a highly effective method available to reduce the risk of unintended pregnancy when it is taken within 120 hours of unprotected intercourse, and EC has been shown to decrease the risk of pregnancy by 75% (Trussell,

Ellerston, Stewart, Raymond & Shochet, 2004). Prior to the 2006 Federal Drug Administration (FDA) decision to make EC pills available over the counter to individuals 18 years and old at pharmacies and health clinics, these pills were solely available through a prescription. Despite increased access to oral EC neither abortion nor unintended pregnancy rates have decreased in the U.S. (Raymond, Trussell & Polis, 2007). The reason for this lack of change is unclear.

Numerous studies have investigated predictors and characteristics of women who access EC. A survey of approximately 7,000 women aged 15-44 in California who were aware of EC and were at risk of pregnancy found that young age, low income, and having no source of health care or attending community or government health clinics significantly increased a woman's likelihood of using EC (Baldwin, Solono, Washington, Yu, Huang & Brown, 2008). Findings from a study with women accessing EC at a university clinic suggest that previous use of EC, unprotected sexual intercourse in the last 6 months, and the perceived need for EC within the next 3 months were positively associated with seeking EC. Additionally, women seeking EC were less likely to use a method of hormonal contraception or the IUD (Parrish, Katz, Grove, Maddock & Myhre, 2009). Notably, the percentage of women who have ever used EC has increased from 4% in 2002 to 10% between 2006-08 (Mosher & Jones, 2010).

Unintended Pregnancy

Unintended pregnancy rates remain startlingly high in the United States with nearly half of all pregnancies classified as unintended (Finer & Henshaw, 2006). Women who engage in unprotected sexual intercourse or report inconsistent contraceptive use are

classified as at high risk for unintended pregnancy. In addition, unintended pregnancy has significantly increased among minority women and women with less than a high school education in the past few decades (Finer & Henshaw, 2006). Unintended pregnancy results in over $11 billion in expenditures, approximately 1.3 million abortions, and 434,000 fetal losses each year (Finer & Henshaw, 2006; Sonfield, Kost, Gold & Finer, 2011). Individual factors such as a woman's lack of knowledge about methods, fear of method side effects, and dislike of available methods impact her consistent contraceptive use (Ayoola, Nettleman & Brewer, 2007; Foster et al., 2004; Vaughn, Trussell, Kost, Singh, & Jones, 2008).

Consequences of Unintended Pregnancy

Unintended pregnancy presents serious outcomes for both children and women. Children who are born as a result of an unintended pregnancy have a greater likelihood of having low birth weights and of dying within their first year (Brown & Eisenberg, 1995). Additional negative consequences extend to the child's preschool years. A child born from an unintended pregnancy will likely reach lower academic thresholds and receive fewer developmental resources than a child whose conception was intended (Baydar, 1995). These troublesome negative outcomes may in part be attributed to the behaviors of women who experience an unintended pregnancy. Because a woman with an unintended pregnancy who smokes or uses other substances may be less prepared or motivated to change her behaviors to benefit her fetus, a woman is more likely to smoke throughout her pregnancy and to not seek adequate prenatal care (Hellerstedt et al., 1998). Further, women at higher risk of unintended pregnancy are less likely to seek

consistent health care and sexually transmitted infection (STI) testing (Xaverius, Tenkku & Salas, 2009). Research indicates that women whose pregnancy is unintended face a higher risk of physical abuse throughout her pregnancy than those with intended pregnancies, and a positive association is reported between unintended pregnancy and negative mental health outcomes such as depression and anxiety (Gipson, Koenig & Hindin, 2008; Goodwin, Gazmararian, Johnson, Gilbert & Saltzman, 2000).

The Copper IUD

Increasing the use of an effective method of EC that can further function as a long-term and highly effective method may significantly reduce the unintended pregnancy rates. Long acting reversible contraceptives (LARCs), such as an intrauterine device (IUD), are both highly effective methods of contraceptive and additionally require little action from users once inserted (ACOG, 2009). There are two methods of intrauterine contraception available in the United States. The first method, the levonorgestrel intrauterine system (LNG-IUS), provides up to 5 years of protection. It functions by releasing low levels of levongestrel into the uterus, which thickens the cervical mucus, inhibiting ovulation and sperm survival (Fantasia, 2008). The second intrauterine contraceptive is the copper IUD. The copper IUD functions as an effective method of EC when inserted within 7 days of unprotected intercourse, and may continue to serve as a highly effective method of contraception for up to 12 years (Cheng, Gülmezoglu, Piaggio, Ezcurra, & Van Look, 2008; Trussell, et al., 2004). Its dual function may address barriers faced by women vulnerable to an unwanted pregnancy.

Despite its high effectiveness and cost efficiency, IUD use in the United States remains low (Doyle, Stern, Hagan & Gricar, 2008). However, the use of IUDs in the U.S. is increasing. The percentage of IUD use has increased from 2 to 8% among women with one child between 2002 and 2008 (Mosher & Jones, 2010). Compared to users of other contraceptive method users, women who utilize the IUD are more likely to report higher family incomes, be married, be foreign born, and of Hispanic origin (Xu, Macaluso, Frost, Anderson, Curtis, & Grosse, 2011).

The Impact of Health Care Providers

Health care providers may potentially impact both a woman's EC use and contraceptive method choice. A woman's knowledge about and attitudes towards methods of EC are informed by the attitudes and perceptions of her healthcare provider around EC. Female university students indicated they would be much more likely to use EC if they had received information directly from their health care providers (Hickey, 2009). Further, women presenting at family planning clinics reported being more than twice as likely to be interested in an IUD when their health care providers discussed it as an option (Fleming, Sokoloff, & Raine, 2010).

The Impact of Family Planning Clinics

Publicly funded and subsidized family planning clinics fulfill significant and necessary health care and contraceptive needs for uninsured and low-income and women in the United States. Notably, low-income women have experienced drastic increases of abortion within the last decade due to factors such as the lack of access to affordable

reproductive healthcare (Jones & Kavanaugh, 2011). The lack of health insurance is also an important predictor of prescription contraceptive use, such as the IUD. Results from the 2002 Behavioral Risk Factor Surveillance System (BRFSS) survey indicate that 20% of the approximately 27,000 female respondents were uninsured and were more likely to report using no contraceptive method (Culwell & Feinglass, 2007). These results highlight the need for increased health insurance coverage, and maintaining health care access through subsidized and publicly funded family planning clinics for uninsured women.

Nearly 7 million women access publicly funded family planning clinics each year for health and contraceptive care. Services from these clinics are estimated to prevent an average of 242 unintended pregnancies per 1,000 contraceptive method users, translating into 1.4 million fewer unintended pregnancies in 2004 (Frost, Finer & Tapales, 2008). A nationally representative study of publicly funded family clinics indicates that 80 percent of clinics offer a dedicated EC product, and provide other important services such as HIV testing, cancer screening, educational programs, and contraceptive services and counseling (Lindberg, Frost, Sten & Dailard, 2006). Notably, research investigation the contraceptive needs of women accessing services at a publicly-funded STI clinic indicate that participants need access to EC as well as effective ongoing methods of contraception (Godfrey, Wheat, Cyrier, Wong, Trussell & Schwarz, 2010).

The Use of the Copper IUD as a Method of EC

Currently, there is little literature investigating the use of the copper IUD as EC from either healthcare provider or patient perspectives and experiences. To potentially

increase the use of copper IUDs as EC among women presenting for EC, research must explore if healthcare providers are able and willing to offer the IUD as an EC method. Additionally, healthcare provider experiences with and perceptions about the copper IUD as EC must be understood. This knowledge may increase our ability to more effectively reduce unintended pregnancy through the provision of long-term highly effective methods of contraception. In an effort to increase the use of IUDs among women seeking EC, research must explore if healthcare providers are first willing and able to offer it.

Women presenting at family planning clinics for EC may greatly benefit from the use of the copper IUD as EC. A study investigating interest in same-day IUD insertion in women presenting for EC at family planning clinics suggests that efforts should be made to increase education and access to IUD insertion to women seeking EC. Few women seeking walk-in pregnancy tests or EC had knowledge about IUDs, but interest in same-day insertion was high among women familiar with them (Schwarz, Kavanaugh, Douglas, Dubowitz, & Creinin, 2009).

Family planning clinics rely heavily on the expertise of advanced practitioners to provide reproductive care and education (K. Burke, personal communication, May 9, 2011). However, there is no current research exploring the experiences of advanced practitioners in providing EC or inserting the copper IUD. Not only must provider willingness to offer the copper IUD as a method of EC be investigated, but also the barriers they encounter in doing so. The purpose of this study is to explore the question, what are the experiences of Advanced Practitioners with inserting the copper IUD as a form of EC at family planning clinics?

Methods

Recruitment and Data Collection

Advanced Practitioners who worked in family planning clinics were contacted and invited to participate in a one-time semistructured individual interview. Potential participants were recruited from family planning clinics in a Western U.S. city, and from a national conference for reproductive health professionals. Purposive sampling was used to recruit potential participants, and recruitment was limited to Advanced Practitioners with experience inserting the copper IUD at Planned Parenthood clinics in order to achieve typical case sampling (Patton, 2002; Polkinghorne, 2005). Interviews lasted approximately 45 minutes, and included questions around a participant's experiences offering the copper IUD as a method of EC to patients, the occurrence of failed insertion, and their perceptions of the IUD as a form of EC. All interviews were audio recorded and transcribed. Transcripts were read and reread and checked for accuracy. The University of Utah IRB exempted the study for all research protocol.

Analysis

A modified version of the Van Kaam method of phenomenological analysis was utilized to analyze the data for each individual interview. From each participant's complete transcript, every expression relevant to the research question (what are the experiences of Advanced Practitioners with inserting the copper IUD as a form of EC at family planning clinics?) was listed. Each expression was tested for containing a moment of the experience necessary to understand it, and if it was possible to break down the expression into a smaller unit of meaning. Repetitive and vague data were eliminated,

and remaining data were clustered into thematic labels and organized by textural (experience) and structural (perception) descriptions of the phenomena of the experience with and perceptions about inserting the copper IUD as a method of EC (Moustakas, 1994). The results are presented in a thematic portrayal of participants' experiences and perceptions rather than a composite description of all interviews. Two participants served as member-checkers to review initial themes and findings to ensure validity of the analysis. Participant quotes are included to provide further illustration of the analysis and thematic portrayal.

Results

Participant Demographics

Interviews were conducted with 12 Advanced Practitioners. All APs were Caucasian and female. APs had a mean age of 40.25 years (*SD*= 13.41), and had worked in a family planning clinic setting for a mean of 10.41 years (*SD*=9.55). Two APs held doctorates (16.7%); three are certified as Women's Health Nurse Practitioner (WHNPs, 25%), and seven held MSN or other master's degrees (58.3%). Throughout their careers, APs experienced a mean of 17.85 IUD insertion failures (range 3-68, *SD*=19.98) and inserted between 1 and 10 IUDs a week (*M*=5.25; *SD*=3.12). On average, APs worked 29 hours a week in a family planning clinic setting (*SD*=16.09).

Thematic Findings

The results portray the essence of the phenomenon of presenting and inserting the copper IUD as EC. Analysis of the data resulted in six themes describing the perceptions and experiences of APs in offering and inserting the copper IUD as a method of EC.

Personal views towards the copper IUD as EC

AP views towards the copper IUD as a method of EC were shaped by how they defined their roles in their clinic setting. In addition to providing health care services for immediate patient needs, a broader and holistic definition of professional roles impacted views on EC method presentation. APs' practice approach was informed by attending to the reproductive education, preventative needs and general well-being of patients.

> I like to focus a lot on education, especially when I have someone coming in. I have very little time with my patients unfortunately, but the time that I do have, I like to talk about contraceptives or I will talk about other, I kind of vary it based on what the patient needs. About weight loss, about healthy habits, healthy living, healthy sex habits, those sorts of things.

APs discussed feeling a sense of responsibility to protect patients from an unwanted pregnancy, which guided them to promote long acting and highly effective methods of contraception.

> I definitely working here have adopted that mission myself so if that patient is ready and willing and meets the criteria then by all means let's get that [the copper IUD] in her and let her leave with more effective method than continually taking a pill or emergency contraception or forgetting her method so I think it is often that I wish we did more of it and we probably can, it is something we can work on with the staff is to provide more education.

AP's past experiences with patients who became pregnant after using EC pills acted as a catalyst to advocate for the use of the copper IUD as a potentially better method of EC.

> I remember I saw one patient who came in for EC. Again, the [Medical Assistant] did most of the counseling, so I was just able to kind of come in and be like any other questions, how are things going? Okay, fine. Here's your meds and go. Unfortunately, her EC didn't work. She became pregnant and a couple months later, I saw that she came through, she had an abortion and she got a Paragard. That was my moment of like oh, my God, I should have offered her Paragard at that time that I saw her for EC. I could have prevented this abortion if I had given her that option.

However, AP's concerns that a nulliparous woman would experience unnecessary pain with a copper IUD insertion for EC caused feelings of hesitation with offering it as an EC method. The belief that many patients could not provide an accurate history of last menstruation, and the last instance of unprotected intercourse in relation to their menstrual cycle led to unwillingness to offer the copper IUD. APs perceived patients as having little knowledge about the copper IUD in general. Consequently, APs worried that an uninformed patient may return to the clinic quickly to have her IUD removed. Further, APs may prefer the copper IUD as a method of EC, yet recognize the high and unexpected cost of an IUD for patients unprepared for the expense.

Perceived patient views of the copper IUD as EC

APs could not identify many patients who had previous knowledge about the copper IUD's ability to function as a method of EC. APs perceived patients to be more willing to select the copper IUD as either a method of EC or as contraception if they were able to reference a friend or family member who had one. Younger patients presented

with unique barriers to using long-term methods of contraception, including the copper IUD.

> I don't know if that's true in other places in the state or in other places in the country, but there tends to be a lot of guilt associated with sexual intercourse and so [they] tend to be at times very apprehensive about birth control, which is ironic.

Such patients may present multiple times for EC, yet were described as not wanting continuing methods of contraception. APs believed that patients viewed accessing EC pills as acceptable because patient sexual intercourse was unplanned, while using a method of birth control would give them permission to engage in premeditated or planned intercourse. APs perceived that detailed discussions about the copper IUD as EC are necessary for patients to have adequate knowledge to make an informed decision.

> I think that people who take it as EC who are trying to get talked into it are more likely to have it taken out because they don't necessarily get a realistic picture versus when we're discussing IUDs with people as a contraception and talking about what's the difference between Paragard and a Mirena.

Process of presenting the copper IUD as method of EC to patients

Clinic organization impacted which EC seekers were seen by APs. Women presenting at clinics for EC were generally seen by the front office medical staff, therefore limiting APs' experiences seeing all patients seeking EC. Because EC pills are available over the counter to most patients, APs did not see patients who were solely seeking EC.

> I don't see patients who come in just for that reason [EC] they see the clinic assistant, if they are here for an exam then you know that is an option for birth control and for EC, but if they are in just for emergency contraception then most

> of them don't even need a prescription so it is just handed to them over the counter and then those who are minors, a clinic assistant does that.

Clinic support of offering the copper IUD as a method of EC influenced an AP's decision or ability to offer it to their patients. Participation in a prospective clinical trial where potential participants were offered either the copper IUD or oral EC provided an opportunity for participants and clinic staff to discuss the two options with patients. Clinics with limited employee experience inserting an IUD as a method of contraception were viewed as less supportive of presenting the copper IUD as EC. APs describe a thorough discussion process of explaining the copper IUD to patients. Providing adequate information on the IUD and its side effects to patients is viewed as a deterrent to IUD removal:

> I really like to talk to them about the IUD, about the advantages of the IUD and I talk to them about the disadvantages as well because I want them to go in informed, otherwise I put it in and a week later I pull it out.

APs did not think patients had knowledge of the copper IUD's function as EC in general. APs perceived that the IUD's ability to provide long-term contraception may interest women seeking EC when they were given information about it.

Process of inserting the IUD

APs first describe the procedure to the patient, and then attempt to fit the IUD. APs described feelings of "knowing" if an insertion would be a failure or success.

> You get a feeling, you have tried and tried and tried and then you just by then know and so I don't have a set number or anything, but sometimes if it feels like it is going to go, when you are inserting them, I feel like you can feel when you are going to get it.

The possibility of perforating a patient's uterus or causing tearing also led APs to discontinue an insertion attempt.

> Like sometimes I'll get right to there and I'll kind of hold firm pressure on it and then it will go through, but sometimes it will get right to there and you will hold firm pressure and there is still absolutely nothing and then you think if I push I'm going to tear some tissue and I'm not going there so.

APs relied on patient pain feedback during the insertion process. They were cognizant of patients' pain threshold and gauged how far they will go with an insertion based on a patient's pain response. Patients who were identified as more committed to receiving the copper IUD were viewed as having higher tolerance during the insertion process.

> Yeah, because those are the people who really want the IUD and they're kind of committed to getting the IUD. They're going to try as many times as they can versus sometimes people who the attempted insertion was more uncomfortable then they expected, they're like done. No, I'm going to take those pills.

APs did not differentiate between an IUD insertion done for EC or for contraception, and followed the same insertion protocols.

Instances of failed insertions

In instances of failed IUD insertion, APs identified why the insertion was not successful and further described backup methods for a follow-up insertion attempt.

> Failed is most likely you are not able to sound the uterus. We always measure the uterus first and so can't get it past the internal os up into the uterus so we can't sound and so then can't get it in. So then sometimes we'll do Misoprostol to try and then we have to have them come back.

APs identified the importance of access to an experienced MD with higher insertion success than their own. Patients tended to be willing to make an appointment at

a later date and return to a clinic with an MD to receive an IUD. The definition of a failed insertion extended beyond an AP's ability to successfully insert an IUD, and included women who returned to the clinic within a short time period for an IUD removal. A patient experiencing discomfort, bleeding, or believing that when used a method of EC, the copper IUD did not also function as a long-term method of contraception, explained reasons for IUD removal. Instances of IUD removal were attributed are to a patient's lack of preparedness. Although numerous specific backup methods were identified and considered in each IUD insertion failure incident, several attempts were made first to insert the IUD.

Discussion

The results of this study provide insight into the experiences with and perceptions about the copper IUD as a method of EC among APs working within family planning clinic settings. While APs may generally favor the use of the copper IUD as a method of EC in most circumstances, they were cognizant of numerous factors influencing its efficacy and long-term use beyond that initial purpose. Similar to other studies exploring contraceptive method selection, APs in this study reported patient barriers to contraceptives including high cost and lack of knowledge (Campo, Askelson, Spies & Losch, 2010; Homco, Peipert, Secura, Lewis & Allsworth, 2009; Ayoola, Nettleman & Brewer, 2007). Patient characteristics, such as age, knowledge of the IUD and sexual history, further influenced APs' perceptions about the use of the copper IUD as EC. In addition, perceived patient pain and fear of tissue tearing led APs to discontinue an IUD insertion attempt.

Few studies have investigated the use of the copper IUD as a method of EC from either the patient or provider's perspective. Participants in this study were unsure of patient knowledge of the copper IUD as EC. Worry that women may request IUD removal soon after insertion further yielded hesitation among APs in offering the copper IUD to women seeking EC. A prospective observational study investigating patients use of oral EC or the copper IUD as EC found reported significant outcome differences between women selecting the copper IUD and oral levongestrel as EC. Not only were there no pregnancies reported in the copper IUD group, women who selected the copper IUD as EC versus oral EC were also significantly more likely to be using effective contraception at the 1- and 6-month follow-ups compared to those who selected oral EC. Furthermore, nearly 40% of women enrolled in the study selected the copper IUD as their preferred method of EC (Turok, Gurtcheff, Handley, Simonsen, Sok, & Murphy 2010). Findings from this study indicate that when offered, there is indeed interest in a method of EC that can function as a long-term method of contraception. Additionally, use of the copper IUD as EC may potentially result in more use of highly effective methods of contraception following method nonuse or failure.

A previous study with practitioners on the use of the copper IUD as a method of EC reported time constraints, lack of training, and personal beliefs to be barriers to offering the IUD as EC to patients (Reuter, 1999). While APs in the current study did not identify time or training as potential barriers to offering the copper IUD, personal beliefs about the copper IUD as EC did in fact influence participant willingness to offer or insert the IUD as EC. Perceptions about the potentially short-term use of the IUD among younger patients, the unreliability of patient's sexual history, and the fear of inflicting

unnecessary pain to nulliparous women deterred APs from presenting it as an EC option. Promoting support between family planning clinics, and sharing practitioner experiences with inserting the copper IUD as EC may assist to address these perceptions and increase practitioner comfort with the copper IUD as EC.

Limitations

The results of this study are limited to the experiences of the participants, and of Advanced Practitioners employed in family planning clinic settings in the Western United States. Their experiences and perceptions may not be representative of Advanced Practitioners throughout the U.S., or those employed in other clinical settings.

Recommendations

Advanced Practitioners provide important and much-needed services to women who rely on family planning clinics for education and reproductive health care. Results from this study indicate a need for further discussion between practitioners and patients around EC and contraceptive method options before women present at clinics for EC. Additionally, all clinic staff should be aware of the use of the copper IUD as EC, and discuss this option to women presenting for EC. Front office staff are often the first and only staff to interact with women presenting at clinics for EC. Providing information on the copper IUD as a method of EC may increase the number of EC seekers seen by APs. Increasing communication among APs about methods used to increase successful IUD insertion may further serve to increasing the use of the copper IUD as EC. Future

research should explore the experiences and perceptions of APs in other clinical and geographical settings.

References

ACOG Committee Opinion (2009). Increasing uses of contraceptive implants and intrauterine devices to reduce unintended pregnancy. *Obstetrics & Gynecology, 114*(6), 1434-1438.

Ayoola, A.B., Nettleman, M., & Brewer, J. (2007). Reasons for unprotected intercourse in adult women. *Journal of Women's Health, 16*(3), 302-310. Doi: 10.1089/jwh.2007.0210

Baldwin, S.B., Solono, R., Washington, D.L., Yu, H., Huang, Y.C., & Brown, R. (2008). Who is using emergency contraception? Awareness and use of emergency contraception among California women and teens. *Women's Health Issues, 18,* 360-368. doi: 10.1016/j.whi.2008.06.005

Baydar, N. (1995). Consequences for children of their birth planning status. *Family Planning Perspectives, 27*(6), 228-234.

Brown, S.S., & Eisenberg, L. (1995). *The best intentions: Unintended pregnancy and well-being of children and families.* Washington, DC: National Academy Press.

Campo, S., Askelson, N.M., Spies, E.L., & Losch, M. (2010). Preventing unintended pregnancies and improving contraceptive use among young adult women in a rural, Midwestern state: Health promotion implications. *Women & Health, 50*(3), 279-296. Doi: 10.1080/03630242.2010.480909

Cheng, L., Gülmezoglu, A.M., Piaggio, G.G.P., Ezcurra, E.E., & Van Look, P.P.F.A. (2008). Interventions for emergency contraception. *Cochrane Database of Systematic Reviews, 2.* Doi: 10.1002/14651858.CD001324.pub3

Culwell, K.R., & Feinglass, J. (2007). The association of health insurance with use of prescription contraceptives. *Perspectives on Sexual and Reproductive Health, 39*(4), 226-230. Doi: 10.1363/3922

Doyle, J., Stern, L., Hagan, M., Hao, J., & Gricar, J. (2008). Advances in contraception: IUDs from a managed care perspective. *Journal of Women's Health, 17*(6), 987-992. Doi: 10.1089/jwh.2008.0814

Fantasia, H.C. (2008). Options for intrauterine contraception. *Journal of Obstetric, Gynecologic & Neonatal Nursing,37,* 375-383. Doi: 10.1111/j.1552-6909.2008.00249.x

Finer, L.B., & Henshaw, S.K. (2006). Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual & Reproductive Health, 38*(2), 90-96.

Fleming, K.L., Sokoloff, A., & Raine, T.R. (2010). Attitudes and beliefs about the intrauterine device among teenagers and young women. *Contraception, 82,* 178-182. Doi: 10.1016/j.contraception.2010.02.020

Foster, D.G., Bley, J., Mikanda, J., Induni, M., Arons, A., Baumrind, N., Darney, P.D., & Stewart, F. (2004). Contraceptive use and risk of unintended pregnancy in California. *Contraception, 70*(1), 31-39.

Frost, J.J., Finer, L.B., & Tapales, A. (2008). The impact of publicly funded family planning clinic services on unintended pregnancies and government cost savings. *Journal of Health Care for the Poor and Underserved, 19*(3), 778-796. DOI: 10.1353/hpu.0.0060

Gipson, J.D., Koening, M.A., & Hindin, M.J. (2008). The effects of unintended pregnancy on infant, child, and parental health: A review of the literature. *Studies in Family Planning, 39*(1), 18-38.

Godfrey, E.M., Wheat, S.G., Cyrier, R., Wong, W., Trussell, J., & Schwarz, E.B. (2010). Contraceptive needs of women seeking care from a publicly funded sexually transmitted infection clinic. *Contraception, 82,*543-548. DOI: 10.1016/j.contraception.2010.03.007

Goodwin, M.M., Gazmararian, J.A., Johnson, C.H., Gilbert, B.C., Saltzman, & the PRAMS Working Group. (2000). Pregnancy intendedness and physical abuse around the time of pregnancy: Findings from the Pregnancy Risk Assessment Monitoring System, 1996-1997. *Maternal & Child Health Journal, 4*(2), 85-92.

Hellerstedt, W.L., Pirie, P.L., Lando, H.A., Curry, S.J., McBride, C.M., Grothaus, L.C., & Nelson, J.C. (1998). Differences in preconceptional and prenatal behaviors in women with intended and unintended pregnancies. *American Journal of Public Health, 88*(4), 663-666.

Hickey, M.T. (2009). Female college students' knowledge, perceptions, and use of emergency contraception. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 38,* 399-405. Doi: 10.1111/j.1552-6909.2009.01035x

Homco, J. B., Peipert, J. F., Secura, G. M., Lewis, V. A., & Allsworth, J. E., (2009). Reasons for ineffective pre-pregnancy contraception use in patients seeking abortion services. *Contraception, 80,* 569-574.

Jones, R.K., & Kavanaugh, M.L. (2011). Changes in abortion rates between 2000 and 2008 and lifetime incidence of abortion. *Obstetrics & Gynecology, 117*(6), 1358-1366. Doi: 10.1097/AOG.0b013e3182c405e

Lindberg, L.D., Frost, J.J., Sten, C., & Dailard, C. (2006). The provision and funding of contraceptive services at publicly funded family planning agencies: 1995-2003.

Perspectives on Sexual & Reproductive Health, 38(1), 37-45. Doi: 10.1111/j.1931-2393.2006.tb.00057.x

Mosher, W.D. & Jones, J. (2010). Use of contraception in the United States: 1982 to 2008. *Vital & Health Statistics, 23*(29). Retrieved March 13 2012, from http://www.cdc.gov/nchs/data/series/sr_23/sr23_029.pdf

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Patton, M.Q. (2002). *Qualitative evaluation and research methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Parrish, J.W., Katz, A.R., Grove, J.S., Maddock, J., & Myhre, S. (2009). Characteristics of women who sought emergency contraception at a university-based women's health clinic. *American Journal of Obstetrics & Gynecology, 201,* 22e1-27. Doi: 10.1016/j.ajog.2009.03.012

Polkinghorne, D.E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology, 52*(2), 137-145. 10.1037/0022-0167.52.2.137

Raymond, E.G., Trussell, J., & Polis, C.B. (2007). Population effect of increased access to emergency contraceptive pills. *Obstetrics & Gynecology, 109*(1), 181-188.

Reuter, S. (1999). Barriers to the use of IUDs as emergency contraception. *The British Journal of Family Planning, 25*(2), 63-68.

Schwarz, E.B., Kavanaugh, M., Douglas, E., Dubowitz, T., & Creinin, M.D. (2009). Interest in intrauterine contraception among seekers of emergency contraception and pregnancy testing. *Obstetrics & Gynecology, 113*(4), 833-839.

Sonfield, A., Kost, K., Gold, R.B., & Finer, L.B. (2011). The public costs of births resulting from unintended pregnancies: National and state-level estimates. *Perspectives on Sexual and Reproductive Health, 43*(2), 94-102. Doi: 10.1363/4309411

Turok, D.K., Gurtcheff, S.E., Handley, E., Simonsen, S.E., Sok, C., & Murphy, P. (2010). A pilot study of the copper T380A IUD and oral levonorgestrel for emergency contraception. *Contraception, 82,* 520-525. Doi: 10.1016/j.contraception.2010.06.001

Trussell, J., Ellerston, C., Stewart, F., Raymond, E.G., & Shochet, T. (2004). The role of emergency contraception. *American Journal of Obstetrics & Gynecology, 190,* S30-38. Doi: 10.1016/j.ajog.2004.01.063

Vaughan, B., Trussell, J., Kost, K., Singh, S., & Jones, R. (2008). Discontinuation and resumption of contraceptive use: Results from the 2002 National Survey of Family Growth. *Contraception, 78*, 271-283. Doi: 10.1016/j.contraception.2008.05.007

Xu, X., Macaluso, M., Frost, J., Anderson, J.E., Curtis, K., & Grosse, S.D. (2011). Characteristics of users of intrauterine devices and other reversible contraceptive methods in the United States. *Fertility & Sterility, 96*(5), 1138-1144. doi: 10.1016/j.fertnstert.2011.08.019

CHAPTER 4

A PHENOMENOLOGICAL INQUIRY INTO MEN'S EXPERIENCES WITH AND PERCEPTIONS OF EMERGENCY CONTRACEPTION

Abstract

Emergency contraceptives (EC) are methods available to decrease the likelihood of unintended pregnancy following unprotected intercourse, yet little EC research has been conducted involving males. Focus groups were held with 19 heterosexually active men and the data were analyzed following phenomenological methods. Findings include the meaning of unprotected intercourse and method failure, the meaning of emergency contraception, sense of responsibility, and woman's body/woman's decision. Recommendations are given to increase male knowledge and access around EC and for future research.

Background

Men and women in the United States are presented with numerous contraceptive method choices. Issues including personal preference, access, cost, and the impact of sexual partners influence method selection. While most sexually active adults have utilized a method of contraception at one point, consistent use is affected by numerous

factors. Barriers such as a dislike of method side effects, lack of information, and the high cost of contraceptive methods inhibit the consistent use of a method of contraception (Ayoola, Nettleman & Brewer, 2007; Campo, Askelson, Spies & Losch, 2010; Homco, Peipert, Secura, Lewis & Allsworth, 2009; Mills & Barclay, 2006). Results from the 2002 National Survey of Family Growth suggest that contraception method discontinuation is high. Over 67% of all methods were discontinued within a 12-month period, and was highest with the use of the male condom, withdrawal, and fertility-awareness. Although most individuals reported a resumption of contraceptive use, approximately 25% of respondents used no method following a discontinuation (Vaughan, Trussell, Kost, Singh & Jones, 2008). These findings indicate that many couples may face periods of unprotected intercourse, and risk unintended pregnancy in times of method discontinuation.

In order to reach gender equality, and ultimately a healthy society, the 1994 International Conference on Population and Development called for men's involvement in reproductive health matters. To attain this goal, reproductive health frameworks must be shifted to include men (Bustamante-Forest & Giarratano, 2004). Methods, such as emergency contraception (EC), are available to decrease the likelihood of unintended pregnancy, yet little EC research has been conducted involving males.

Literature Review

The Role and Influence of Male Partners on Contraceptive Use

Men impact the use of contraception, as well as which method is selected for use. However, men's expected roles in contraceptive decision-making may be influenced by

their gender. An exploratory study conducted with 30 opposite-sex couples indicate that both men and women learn about contraception through socialization, yet what they learn is markedly different. Men reported receiving information solely around condoms, while none reported receiving information on female-centered methods, such as hormonal contraceptives. Moreover, participants expressed beliefs that men held responsibility for male methods, such as condoms, while females held responsibility for the use of female-centered methods (Fennell, 2011).

The nature of specific sexual relationships further influences a couples' contraceptive use. Research demonstrates that little to no method discussion occurs between partners in casual relationships, limiting the use of effective contraception. (Raine et al., 2010). Further, long-term methods of contraception have been found to be associated with long-term relationships (Wright, Frost & Turok, 2012). Conversely, long-term relationship status may not result in consistent contraceptive use. A longitudinal study on the associations between low-income women's relationship characteristics and contraceptive use suggests that couples in established sexual relationships may have less motivation to avoid pregnancy, and therefore be less likely to use a contraceptive method (Wilson & Koo, 2008). Thus, it is unclear on the exact effect of a sexual relationship on contraceptive behaviors.

A male's knowledge of contraceptive methods impacts their ability to negotiate contraceptive use with their partners. Men often overestimate their reproductive health knowledge, highlighting the need for male-friendly and male-inclusive health services (Makenzius, Gåden, Tydén, Romild & Larsson, 2009). Men may want to increase involvement in contraceptive use and decision-making. Yet socialization, policies and

healthcare providers help to alleviate them from responsibility through focusing programs and services primarily on women (Ringheim, 1996).

Men's Knowledge of EC Methods

When taken within 120 hours following a method failure or unprotected intercourse, EC is highly effective in reducing the risk of unintended pregnancy. The most common method of EC is progestin-containing pills available either behind the counter to women and men over 16 years of age or through healthcare clinics. EC pill use is considered safe for nearly all women, and decreases the risk of pregnancy by 75% by delaying or preventing ovulation. Further, the use of EC pills has no effect on an established pregnancy (Trussell, Ellerston, Stewart, Raymond, & Shochet, 2004).

As an alternative, a copper intrauterine device (IUD) may be inserted as a form of EC up to 7 days following ovulation (Trussell, et al., 2004). The copper IUD is a small, t-shaped device wrapped in copper wire inserted into the uterus, which prevents fertilization by copper's cytotoxic effect on sperm and the increased inflammatory activity within the uterine cavity. The precise mechanism of action for the copper IUD used in the EC setting is not known. However, it is extremely effective at preventing pregnancy after unprotected intercourse with zero pregnancies in nearly 2,000 women using the copper T380 IUD for EC. Despite increased access to EC, the rates of both unintended pregnancy and abortion have not decreased (Raymond, Trussell & Polis, 2007). Gaining deeper understanding of males' perceptions of EC may help address EC's lack of effect on unintended pregnancy rates.

Research appears to be restricted to males' experiences and perceptions of EC pills rather than the copper IUD as a form of EC. A recent study investigating the perceptions and barriers of male access to EC reports that 78% of both male and female respondents believe men should always be able to purchase EC. However, half of male participants did not know where to obtain EC, and nearly 20% of males were unaware of EC (Nguyen & Zaller, 2009). Men may in fact play crucial roles in decisions to use EC following unprotected sexual intercourse or a method failure. Women interviewed about their decisions whether to include their male partners in accessing EC report that it was often their male partners who initiated discussions around the use of EC (Daugherty, 2011). However, men's perceptions about EC are not known.

Notably, studies reporting EC discussions between patients and healthcare providers limit findings to conversations with female patients (Corbett, Mitchell, Taylor, & Kemppainen, 2005; Kavanaugh & Schwarz, 2008; Lawrence, Rasinski, Yoon & Curlin, 2010; Vahratian, Patel, Wolff & Xu, 2008). Although males may be interested in accessing it, EC continues to be predominantly viewed as a female issue. Currently, there is little research investigating males' conceptualization of EC and experiences accessing it. Policymakers and practitioners are therefore limited in their abilities to increase male involvement with EC. The purpose of this study is to explore the experiences with and perceptions about EC among heterosexually active men.

Theoretical Frameworks

This study utilized two systems-focused theoretical frameworks to explore the use of and perceptions about EC in a heterosexually active male population. Ecological

Systems Theory (EST) asserts that an individual's development and behavior are shaped through processes and interactions between the individual and his/her environments (Bronfenbrenner, 1979). EST attempts to explain how different levels of environments influence an individual, and how individuals will respond differently to their environments. The interactions between a woman and her environments must be examined to understand their influence on her behaviors related to EC. A male partner's perceptions of EC, and past experiences accessing it is purported to have an influence on a woman's use of EC.

Environments are organized into four levels of systems: the micro, meso, exo, and macro systems. The micro-system comprises the roles, activities, and interpersonal relations that an individual experiences within a particular face-to-face setting. A micro-system further contains the belief systems of other individuals within the setting. Belief systems are defined and bound by the particular culture an individual lives within, and will vary over time and location. Belief systems are built and influenced by the socialization done with others such as peers and sexual partners, and further define the ways through which an individual will interact with others within a particular context, or around a specific issue such as EC. The meso-system is a system of micro-systems, which consist of connections and processes occurring between two or more settings. A meso-system exists when an individual engages in behaviors or activities in more than one setting. The EC perceptions of an individual's peers and what he/she is taught in school will impact how he/she views EC.

The exo-system includes the relationships and processes occurring between two or more meso-systems. The relationship between the values around contraception, sexual

behavior, and expected gender roles within a sexual partner's family, and the relationship between the sexual partner and a woman are considered exo-system influences on the perceptions and utilization of EC. Macro-systems refer to the consistency observed within a given culture or subculture in the form and content of micro, meso, and exosystems, as well as any belief systems. The stigmatization of EC by society through policies, political rhetoric, or individual moral beliefs may be a macro-system influence on an individual who is contemplating the use of EC.

The second systems-theory framework used to guide this study is Gender Systems Theory (Ridgeway & Correll, 2004). Gender is described as a system of hegemonic social practices within society. The gender system is supported by current cultural beliefs, or rules, which define characteristics of males and females and further guide how they are expected to behave. Gender Systems Theory assumes individuals define themselves in relation to others, and expect that others will treat them according to existing gender beliefs, even if these beliefs are not personally supported.

These beliefs further influence the distribution of resources, such as contraception education, support, and conversations between healthcare providers and patients based on a patient's gender. The current gender system is further supported by social relational contexts. These contexts influence the maintenance or change within an existing gender system. Gender is heavily involved in reproductive and heterosexual behaviors, and the roles men and women are expected to play within these contexts (Ridgeway & Correll, 2004). For example, men and women's roles and responsibilities around EC, and expected knowledge and access to EC are based on gender. Additionally, how men and

women are expected to behave following unprotected sexual intercourse, and the consequences of unprotected intercourse are situated within a gendered system.

Methods

Qualitative research methods allow for examining complex social interactions within an individual's social and cultural settings, and additionally explore the individual meanings assigned to those experiences. Further, qualitative research designs are emergent, naturalistic and interpretive approaches to investigate processes and the socially constructed nature of reality (Denzin & Lincoln, 2005). Qualitative research is situated within the social, political, and cultural settings of the participants and researcher, thus allowing for understanding of study findings within these specific contexts (Creswell, 2007). Qualitative methods fit this study due to the nature of social and political parameters on and use of EC. Current research has not yet explored males' experiences and perceptions about EC, and the meanings males assign to EC.

Recruitment and Data Collection

Heterosexually active males aged 18 to 40 were recruited from a university setting. Purposive and snowball sampling techniques were utilized. Informational fliers were displayed in the lobbies of a College of Social Work with study details and contact information. Female students were also asked to refer interested male friends or partners. Announcements were made in bachelor and graduate-level Social Work and Business Administration classes and interested students were given researcher contact information.

The authors anticipated participants to have little experience accessing or discussing EC with female partners and healthcare providers due to EC's predominate definition of being a female-specific method. Focus groups were consequently selected as the most appropriate method of data collection for this study. The interactive and process-oriented nature of focus group data collection allows for participants with limited knowledge or experience of a particular topic to develop perceptions throughout the data collection process based on responses elicited from other participants (Krueger & Casey, 2000). Self-contained focus groups allow for efficient gathering of a large amount of qualitative data when the research interest is placed upon not only what participants think about the topic, but also how and why they think the ways they do (Krueger & Casey, 2000; Morgan, 1997).

Four focus groups were conducted in a university setting and were facilitated by a male moderator. Due to gender role socialization, males may experience difficulties in expressing feelings and thoughts (Norwinski, 1993). Because of limited and gendered socialization around EC, a male facilitator was selected as more appropriate than a female-only facilitator in assisting male research participants to share their feelings, beliefs, and perceptions regarding EC. Focus groups were audio-recorded and transcribed.

Phenomenology

This study utilized a phenomenological approach to data gathering and analysis. Phenomenology is the exploration of an individual's lived experiences, and the meanings created about a particular phenomenon (Creswell, 2007). The phenomenon explored in

this study is the use of and perceptions about EC among heterosexually active men. Males' perceptions of and experiences with EC were explored, as well as the relationships between their perceptions and experiences. Rather than attempting to explain participant experiences, this study provides descriptions of participants' thoughts, feelings, and ideas constituting their experiences and perceptions. A component of phenomenological research is Epoche, wherein researchers actively attempt to set aside personal understandings, experiences, and judgments related to the phenomenon. Epoche occurs throughout the research process, and allows for an open and naïve approach to the phenomenon under study. Existing biases are recognized, and bracketed during the research process in order to minimize subjective interpretations of the findings (Moustakas, 1994).

Analysis

Individual responses were analyzed within each focus group. Data relevant to the research question were listed, and participant's repetitive and vague expressions were eliminated. The remaining data that were relevant to the study were organized into thematic labels or categories and organized by descriptions of experience with and perceptions about EC among heterosexually active men (Moustakas, 1994). The results are presented in a thematic portrayal of participants' experiences and perceptions rather than a composite description of all focus groups. Participant quotes are included to provide further illustration of the analysis. IRB approval was obtained from the University of Utah for all study procedures.

Results

Participant Demographics

Four focus groups were held with three to five participants in each group for a total of 15 participants. Focus groups lasted approximately 45 minutes. Participants had a mean age of 31.6 years and reported an income range of less than $20,000 to $70,000. Please refer to Table 4.1 for further demographic information, including primary methods of contraception use, health insurance status, and relationship status. Participants were given pseudonyms.

Thematic Findings

Three participants reviewed the thematic findings and provided feedback. The results from the study are presented in four thematic findings illustrating the phenomenon of how the participants perceived and experienced EC: meaning of unprotected intercourse/method failure, the meaning of emergency contraception, woman's body/woman's decision, and sense of responsibility.

Meaning of unprotected intercourse/method failure

Participants did not discuss personal experiences of unprotected sexual intercourse unless it related to attempting to impregnate their partner. Unprotected intercourse was described as "irresponsible" and being "caught up in the moment". The use of a contraceptive method was identified as important and a preventative measure against pregnancy, as well as sexually transmitted infections among participants who were single.

Table 4.1

Participant Demographics

Name	Race	Relationship Status	Education	EC Discussion with HCP	Previous EC Use	Contraceptive Methods Used	Current Desire for a Child
Samuel	Caucasian	Married	4-year degree	No	No	Withdrawal, Condoms	Not now, but in future
Patrick	Caucasian	In relationship/ Living separately	Some grad school	Yes	No	Oral birth control	Not now, but in future
Brian	Caucasian	Married	Some college	No	No	Oral birth control	No
Elliott	Caucasian	Living w/ Partner	4-year degree	Yes	Yes	Oral birth control	Not now, but in future
Nathan	Caucasian	Living w/ Partner	Some college	No	No	None	No
Michael	Caucasian	Polyamorous	High School	No	No	Vasectomy	No
James	Caucasian	In relationship/ Living separately	High School	No	No	Condoms, Oral birth control	Not now, but in future

Table 4.1 (Continued)

Name	Race	Relationship Status	Education	EC Discussion with HCP	Previous EC Use	Contraceptive Methods Used	Current Desire for a Child
Jonas	Caucasian	Married	Associate's Degree	No	No	IUD	No
Richard	Caucasian	Married	Some grad school	No	No	None, condoms Oral birth control	Yes
Matthew	Asian	Married	Some grad school	No	No	Condoms, Oral birth control	No
Mark	Caucasian	Single	4-year degree	No	Yes	IUD, Oral birth	Not now, but in future
Paul	Caucasian	Married	4-year degree	No	Unsure	Condoms, IUD	No
Luke	Caucasian	Married	Some college	No	No	Rhythm Method	No

Table 4.1 (Continued)

Name	Race	Relationship Status	Education	EC Discussion with HCP	Previous EC Use	Contraceptive Methods Used	Current Desire for a Child
Eddy	Caucasian	Married	Some grad school	No	No	Condoms, Oral birth control	Yes
Alex	Caucasian	Married	Graduate Degree	Unsure	Unsure	Nuva Ring	Not now, but in future

Further, a method failure was not described similarly to unprotected sex because participants took action to engage in protected sexual intercourse. Method failure, including a condom breaking and the female partner forgetting to take the pill, were described as being recognized after sexual intercourse.

> And contraception, like that includes like oral contraception, yeah, where that [method failure] happened, the conversation happened after the fact and it's like oh my God, okay. All right. Well I'm glad that there was at least some form, but that wasn't necessarily me being proactive. It's reactive (Mark, Single).

Participants reported feelings of anxiety and stress to describe the period of waiting to find out the result of a method failure. The possibility of an unintended pregnancy was viewed negatively, but not something that would be necessarily terminated. Possible actions following method failure were identified as “overreacting” included abortion and utilizing EC.

> The scare for us wasn't that we would have overreacted in our minds and let's say aborted the baby or did a day after pill. The anxiety and the panic came from now we're going to have a kid and the expenses with the kid, the responsibility (Alex, Married).

> In my opinion, with my wife and I, it's our belief system that it's not okay ever [EC], but I can't speak for someone who is raped or it's something that is just out of their control so I can't speak for them, but in our family it's we've decided that it's not okay (Samuel, Married).

Meaning of emergency contraception

Participants defined the meaning they assigned to EC based on personal or moral beliefs around pregnancy. While not necessarily personally viewing EC as reckless,

participants believed others perceive EC as irresponsible and a result of being unprepared. Participants believed there still exists stigma towards those who access it.

> Like on one level I see it as a responsible alternative to coat hanger methods so, but at the same time it's like reactionary instead of planning for the future. So it's hard to say like putting an over-arcing label or theme or saying that someone is one way or another because people wear so many different hats at so many different times (Patrick, In a relationship).

> If it's just go out and do whatever and then the next day go get the pill, that is definitely a more negative opinion of that because it's just less responsible, but if it's just kind of something happened, we've got to do something. Yeah, the guy with a glove box full of morning after pills is a little bit different than the guy with a glove box full of condoms (Matthew, Married).

EC is defined as a back-up method after an initial or primary method has failed to avoid an unintended pregnancy.

> Like something after the fact where best laid plans didn't wind up working out and now there's a potential for pregnancy (Richard, Married).

> You have sexual intercourse and there is a risk of pregnancy, an unwanted pregnancy, so you use Plan B. That's the reason they named it that. Something to fall back on. Something that if all else falls through, there's the best laid plans (Mark, Single).

Participants did not think of the copper IUD as EC because they viewed it as "planned", preventative method, not fitting within their definition of EC:

> I thought an IUD was more of a planned thing. I didn't know that was an emergency [method] (Patrick, In a Relationship).

> Yeah, I did too, and I thought it was, because that is actually inserted in the woman, right, so I didn't think that that actually, I didn't think that stopped the process. Maybe it does, maybe. I thought the morning after pill was Plan B. I thought the copper IUD is preventative, not emergency (Brian, Married).

Sense of responsibility

Participants described feeling a sense of responsibility towards the use of contraception and EC, and described experiences of “both being in it together”.

> It's both of our decision. I mean, we both definitely play a role in that and it's not any one person's decision (Samuel, Married).

However, participants did not know how their partners perceived EC. Most participants reported no previous experience accessing EC and had not discussed the possibility of EC use with their partners.

> We've never had that conversation and so I guess I can't entirely speak for her and what her opinion would be. I've never been put in that situation to have to (Brian, Married).

Participants believed they should take active part in knowing what method of contraception a partner is using, in accessing EC, and a further role if a pregnancy occurred. Participants described feelings of having financial and emotional responsibility to their partner if EC was used.

> I didn't even know that was an option [EC] and so she told me about it and I felt that she shouldn't just do it by herself so I went with her and helped to pay for like half the cost, because it's something like (inaudible) bucks or something (Patrick, In a Relationship).

Woman’s body, woman’s decision

Participants described the choice to use EC as their female partners’ decision and noted that while they have a say in the use of contraception and EC, yet the choice whether to use it was their female partner’s choice.

> I think it's like you have these 50/50 decisions, like 50/50 we want to get a gym membership, but the 1% is going to be mine, because I'm probably

> going to spend more time and that's my interest. A baby is 50/50 too, but it's kind of 51/49 for me and my partner because it's her body. She's the one that's going to go through a lot of it and I'll support her in that (Luke, Married).

Participants defined their roles related to EC as being a support and financially involved. Cultural expectations, such as men and women's individual roles related to a potential pregnancy, were considered.

> I think ideally it should be the couple that decides what to do about emergency contraception, not, but I think realistically, our culture has just kind of defaulted to the woman because, like they were saying, she's the one that deals with it (Patrick, In a Relationship).

Feelings of powerlessness and frustration were used in describing an instance of their partner not choosing to use EC if the participant wanted to and the potential of unintended pregnancy.

> It hasn't really happened to me either, but I could definitely appreciate those feelings of frustration. I mean that is a lifetime of commitment and for someone else to make that decision for you, that would be extremely frustrating (Paul, Married).

> And then also emotionally you've got a child that's yours that's out there running around that you feel like you're responsible for. I mean, I think that's, I don't know, I would be a little bit more forceful, I think probably. Like look, I really don't want this to happen, but then again, it is her body and I don't know if legally you can make someone do that [EC] (Mark, Single).

Discussion

The findings from this study may in part be explained by the gender of the participants, and the roles males are expected to fulfill related to contraception. Participants voiced the general attitudes of both males and females around men's social

roles around contraception and EC access and use. Similar to past studies about males and contraceptive use, our participants noted a desire for both male and female input in contraception decision-making processes. Data from the National Survey of Men reveal that 78% of men in heterosexual relationships reported a move to more egalitarian views around contraception decision-making (Grady, Tanfer, Billy & Lincoln-Hanson, 1996). Although they posit that study responses may in reality reflect ideology more than behaviors, the authors note that a woman's partner nevertheless greatly influences contraceptive behavior while contraception-related policies and programs continue to exclude men.

Notably, few participants had experiences accessing EC. Therefore, the results are largely reflective of perceptions rather than experiences. This reflection may, in part, be explained by wide-held beliefs that the decision to use EC is the woman's, thus limiting the male participants' experiences accessing it. However, participants may be unaware of their partner's previous use of EC. A study exploring the knowledge and use of EC among a university population reported 12% of female participants had previously used EC while only 8% of male participants reported their female partners had used it (Corbett, Mitchell, Taylor & Kemppainen, 2006). This discrepancy may be the result of limited conversations between partners around EC use.

While participants believed men and women hold equal responsibility for deciding to use EC and accessing it, the decision was ultimately seen as the woman's responsibility. Participants were aware of the possible effects of contraceptive methods on their partners, and expressed concern about the effect of hormones. This concern translated into defaulting the decision whether to use EC to the female partner.

Participants further reported having little to no discussion around EC with healthcare providers unless they were with their female partner. This finding illustrates a continued lack of involving males in reproductive health discussions with health care providers. Increasing conversations between providers and male patients may positively impact both males' knowledge and comfort in discussing EC with their partners.

Participants held definite views of EC, and how they believed it functioned. Specific situations, such as rape, sexual assault, and method failure were perceived as acceptable situations for EC use. The possibility of pregnancy in instances of method failure, while not ideal, was described as something that would be carried through and not terminated. Although many participants described instances of method failure, few reported actually utilizing EC. This limited use of EC may be partly explained by low levels of accurate knowledge of EC, and the fear that EC caused an abortion. A systematic review evaluating the effects of increased access to EC on pregnancy rates reveals that common reasons for not taking EC include misconception about EC and how it functions (Raymond, Trussell & Polis, 2007).

The copper IUD was not viewed as a method of EC due to the planning needed to access the IUD, therefore falling outside of the bounds of what EC meant to participants. Previous studies about the copper IUD as EC report limited participant knowledge about the copper IUD's ability to function as EC (Bharadwaj, Saxton, Mann, Jungmann & Stephenson, 2011; Schwarz, Kavanaugh, Douglas, Dubowitz & Creinin, 2009). Therefore, increasing education about EC and expanding discussions around EC to include both oral EC and the copper IUD may address this barrier.

Limitations

The results of this study were gleaned from a predominately Caucasian sample with high levels of education within a university setting in a western city, and should not be generalized to the broader male population. Most participants in the study were in married or cohabitating relationships. Relationship status may have impacted participant's perceptions and experiences around EC. The perceptions and experiences of males in casual sexual relationships may be significantly different than those in long-term sexual relationships. Additionally, not every participant had experiences accessing EC or had a partner who had utilized it; therefore, the results are based primarily on participant perceptions.

Conclusion

The results provide rich descriptions of the complex experiences and perceptions of heterosexual men around EC. The move to include men in reproductive health care discussions and research is an important and growing area. This study provides insight into heterosexually active men's perceptions of and experiences with EC, and the meanings they assign them. Reproductive health education should expand to provide further information on how EC functions, and include information on the copper IUD's ability to function as both EC and a long-term method of contraception.

Health care providers and social work practitioners should expand conversations around EC to male clients, and frame EC and contraceptive methods as both male and female issues. Expanding clinic policies around healthcare provider conversations with male clients will increase knowledge around EC and address issues of its use, available

methods, and implications. Future research should explore the experiences of healthcare providers in providing information on EC to patients and the impact of a patient's gender on EC discussion. Additionally, research should investigate couples' experiences and perceptions of EC from both the male's and female's perspectives. These continued explorations may result in greater understanding of how EC is viewed and will expand the involvement of males in reproductive healthcare.

References

Ayoola, A.B., Nettleman, M., & Brewer, J. (2007). Reasons for unprotected intercourse in adult women. *Journal of Women's Health, 16*(3), 302-310. Doi: 10.1089/jwh.2007.0210

Bharadwaj, P., Saxton, J.C., Mann, S.N., Jungmann, E.M.A., & Stephenson, J.M. (2011). What influences young women to choose between the emergency contraceptive pill and an intrauterine device? A qualitative study. *European Journal of Contraception & Reproduction Health Care, 16*(3), 201-209. Doi: 10.3109/13625187.2011.565891

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Bustamante-Forest, R., & Giarratano, G. (2004). Changing men's involvement in reproductive health and family planning. *Nursing Clinics of North America, 32*(2), 301-322.

Campo, S., Askelson, N.M., Spies, E.L., & Losch, M. (2010). Preventing unintended pregnancies and improving contraceptive use among young adult women in a rural, Midwestern state: Health promotion implications. *Women & Health, 50*(3), 279-296. Doi: 10.1080/03630242.2010.480909

Corbett, P.O., Mitchell, C.P., Taylor, J.S., & Kemppainen, J. (2006). Emergency contraception: Knowledge and perceptions in a university population. *Journal of the American Academy of Nurse Practitioners, 18,* 161-168. Doi: 10.1111/j.1745-7599.2006.00114x

Creswell, J.W. (2007*). Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Daugherty, J.D. (2011). 'Should I tell him?' How women decide to include or exclude their partners in emergency contraception decisions. *International Journal of Sexual Health, 23*(4), 282-296. DOI: 10.1080/19317611.2011.627090

Denzin, N.K., & Lincoln, Y.S. (2005). The discipline and practice of qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 1-41). Thousand Oaks, CA: Sage.

Fennell, J.L. (2011). Men bring condoms, women take pills: Men's and women's roles in contraceptive decision making. *Gender & Society, 25*(4), 496-521. DOI: 10.1177/0891243211416113

Grady, W.R., Tanfer, K., Billy, J.O.G., & Lincoln-Hanson, J. (1996). Men's perceptions of their roles and responsibilities regarding sex, contraception and childrearing. *Family Planning Perspectives, 28*(5), 221-226.

Homco, J. B., Peipert, J. F., Secura, G. M., Lewis, V. A., & Allsworth, J. E., (2009). Reasons for ineffective pre-pregnancy contraception use in patients seeking abortion services. *Contraception, 80,* 569-574.

Kavanaugh, M.L., & Schwarz, E.B. (2008). Counseling about and use of emergency contraception in the United States. *Perspectives on Sexual & Reproductive Health, 40*(2), 81-86.

Krueger, R.A., & Casey, M.A. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage.

Lawrence, R.E., Rasinski, K.A., Yoon, J.D., & Curlin, F.A. (2010). Obstetrician-gynecologist physicians' beliefs about emergency contraception: A national su3rvey. *Contraception, 82,* 324-330. Doi: 10.1016/j.contraception.2010.04.151

Makenzius, M., Gåden, K.G., Tydén, T., Romild, U., & Larsson, M. (2009). Male students' behaviour, knowledge, attitudes, ad needs in sexual and reproductive health matters. *The European Journal of Contraception & Reproductive Health Care, 14*(4), 268-276.

Marshall, C., & Rossman, G.B. (2006). *Designing qualitative research.* Thousand Oaks, CA: Sage.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Norwinski, J.(1993). *Hungry hearts: On men, intimacy, self-esteem, and addiction.* New York: Lexington Books.

Nguyen, B.T., & Zaller, N. (2009). Male access to over-the-counter emergency contraception: A survey of acceptability and barriers in Providence, Rhode Island. *Women's Health Issues, 19,* 365-372. Doi: 10.1016/j.whi.2009.07.003

Raine, T.R., Gard, J.C., Boyer, C.B., Haider, S., Brown, B.A., Hernandez, F.A.R., & Harper, C.C. (2010). Contraceptive decision-making in sexual relationships: Young men's experiences, attitudes, and values. *Culture, Health & Sexuality, 12*(4), 373-386. Doi: 10.1080/13691050903524769

Raymond, E.G., Trussell, J., & Polis, C.B. (2007). Population effect of increased access to emergency contraceptive pills. *Obstetrics & Gynecology, 109*(1), 181-188.

Ringheim, K. (1996). Whither methods for men? Emerging gender issues in contraception. *Reproductive Health Matters, 4*(7), 79-89.

Schwarz, E. B., Kavanaugh, M., Douglas, E., Dubowitz, T., Creinin, M.D. (2009). Interest in intrauterine contraception among seekers of emergency eontraception and pregnancy testing. *Obstetrics & Gynecology, 113*(4), 833-839. doi: 10.1097/AOG.0b013e31819c856c

Trussell, J., Ellerston, C., Stewart, F., Raymond, E.G., & Shochet, T. (2004). The role of emergency contraception. *American Journal of Obstetrics & Gynecology, 190,* S30-38. Doi: 10.1016/j.ajog.2004.01.06

Vahratian, A., Patel, D.A., Wolff, K., & Xu, X. (2008). College students' perceptions of emergency contraception provision. *Journal of Women's Health, 17*(1), 103-111. Doi: 10.1089/jwh/2007.0391

Vaughan, B., Trussell, J., Kost, K., Singh, S., & Jones, R. (2008). Discontinuation and resumption of contraceptive use: Results from the 2002 National Survey of Family Growth. *Contraception, 78*, 271-283. Doi: 10.1016/j.contraception.2008.05.007

Wilson, E.K., & Koo, H.P. (2008). Associations between low-income women's relationship characteristics and their contraceptive use. *Perspectives on Sexual and Reproductive Health, 40*(3), 171-179.

Wright, R.L., Frost, C.J., & Turok, D.K. (2012). A qualitative exploration of emergency contraceptive users' willingness to select the copper IUD. *Contraception,85*(1), 32-35. Doi: 10.1016/j.contraception.2011.04.005

CHAPTER 5

CONCLUSION

This dissertation explored the factors influencing the use of emergency contraception and which methods are selected. The three studies were designed within an Ecological Systems Theory framework in order to understand systemic and environmental influences on EC use and method selection. Qualitative research methods were especially effective and informative in this dissertation because of their focus on participant's social and political specific contexts (Crewell, 2007). Political and social rhetoric continues to attack access to reproductive health services and information. Recent events, such as Rush Limbaugh's public reactions to Sandra Fluke, the proposed Blunt Amendment, enacting ultrasound mandates before abortion, and cuts to men's reproductive health services, all reinforce biases about sexual health needs and maintain the gendered framing of reproductive health issues. Reproductive health and contraception issues are further restricted by religiously and morally driven policies. According to the Guttmacher Institute, there are currently 13 states that allow health care providers to refuse to provide services related to contraception, while all but four states allow exceptions for health care providers to refuse to provide abortion-related services (2012).

Women face persistent obstacles, whether from the media, policies, health care access, or limited knowledge, for obtaining EC services. The findings from the three studies in this dissertation provide timely and much-needed insights into the influences on a woman's EC use and method selection. The results of this dissertation provide potentially valuable information for social workers practicing in health care, policy, and research settings.

Organization and MAP Connections

For Study 1 (Chapter 2), I interviewed women enrolled in a larger prospective clinical trial investigating the selection of oral EC or the copper IUD as a method of EC. In-depth individual interviews were conducted with 14 oral EC users and 14 copper IUD users exploring participants' willingness to select the copper IUD as EC. The results indicate that women think about contraception, as well as EC, within the context of each individual sexual relationship. Long-term methods of contraception, such as the copper IUD, were associated with long-term relationships. Women in short-term or casual sexual relationships did not believe their sporadic sexual activity warranted the expense and commitment of a long-term method of contraception. Prior to study enrollment, participants were not aware of the copper IUD's ability to function as EC. Further, participants identified the high cost of the copper IUD as a barrier to using it as either a method of contraception or EC.

In Study 2 (Chapter 3), in-depth individual interviews were conducted with 12 Advanced Practice clinicians with experience working in family planning clinic settings. Although they may favor the utilization of the copper IUD as a method of EC in most

circumstances, APs identified several factors influencing its selection. APs believed their patients held little knowledge about IUDs either as contraception or as EC. Due to a lack of patient preparedness or knowledge, APs believed that participants would request IUD removal soon after insertion for EC. Further factors, such as the perceived short-term use of the IUD among younger patients and a fear of causing unnecessary pain to nulliparous women deterred APs from presenting the copper IUD as an option for EC.

Study 3 (Chapter 4) explored the perceptions and experiences of heterosexually active males with EC. Focus groups were conducted with 15 males aged 18 to 40. The results indicate that participants defined the meaning of EC based on personal or moral beliefs around pregnancy. Participants believed others still perceived EC as being irresponsible, and a result of being unprepared. Participants defined EC as a back-up method after an initial or primary method has failed to avoid an unintended pregnancy, and did not view the copper IUD as EC. This definition is explained by viewing the IUD as a "planned" and preventative method, thus not fitting within their definition of EC. Participants viewed the selection and use of contraception and EC as a joint process and responsibility. However, participants did not know how their partners perceived EC and had not discussed the possibility of EC use with their partners.

Practice and Policy Implications

Social workers may potentially fill important practice roles advocating for change in reproductive health care education and promoting the use of evidence in the creation and implementation of reproductive health education programs and services. Results from each study revealed low levels of reproductive health and contraception knowledge

among both female and male populations (Studies 1 and 3). Additionally, APs believed their patients held little to no knowledge about the copper IUD, limiting its use as EC (Study 2). Social workers in healthcare and policy settings should promote and encourage increasing access to reproductive and sexual health information.

Policies at the state and national level should reflect the recognition of the importance and impact of reproductive health knowledge on contraceptive use. Utah, like many states, relies on abstinence based sexual and reproductive health education in its public schools. In addition to numerous other restrictions, courses teaching human sexuality in Utah schools cannot promote "the advocacy or encouragement of the use of contraceptive methods or devices, or the advocacy of sexual activity outside of marriage" (Rule R277-474, School Instruction and Human Sexuality). In 2012, the Utah State Legislature passed HB 363, which potentially would have even further restricted what content would be allowed to be taught within public schools around sexual and reproductive health. Governor Gary R. Herbert vetoed the Bill on March 16th, 2012, yet the movement to limit reproductive health and contraception education may have troubling effects on young adults in Utah. Data from the 2006 to 2008 National Survey of Family Growth (NSFG) explored the impact of formal reproductive health education on the timing of first sexual intercourse, contraceptive use, as well as STI and pregnancy prevention among male and female respondents aged 15 to 24. Findings from this recent study indicate that receiving reproductive health care education in addition to abstinence-based education results in both short- and long-term benefits. Individuals who participate in formal reproductive health care education report greater likelihood of delaying the onset of sexual activity, the use of contraception, and the reduced likelihood of males

getting their partners pregnant compared to their counterparts who received abstinence-only education (Lindberg & Maddow-Zimet, in press). Unfortunately, the state legislative actions are contrary to these study findings.

Future Research Implications

The studies conducted in this dissertation provide numerous implications for future research. Future research should:

- Explore the experiences and perceptions of advanced practitioners in other clinical settings.
- Explore the opinions of advanced practitioners around providing other methods of highly effective forms of contraception to women seeking oral EC.
- Explore the experiences of healthcare providers in providing information on EC to patients and the impact of a patient's gender on EC discussion.
- Investigate heterosexual couples' perceptions of EC and experiences accessing it from both the male's and female's perspectives.

These continued research studies may lead to greater understanding of how EC is viewed and will result in better reproductive healthcare.

References

Creswell, J.W. (2007*). Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Harper, C.C., Speidel, J.J., Drey, E.A., Trusell, J., Blum, M., & Darney, P.D. (2012). Copper intrauterine device of emergency contraception. *Obstetrics & Gynecology, 119*(2), 220-226. doi: 10.1097/AOG.0b013e3182429e0d

Lindberg, L.D., & Maddow-Zimet, I. (In press). Consequences of sex education on teen and young adult sexual behaviors and outcomes. *Journal of Adolescent Health.* doi: 10.1016/j.jadolhealth.2011.12.028

State policies in brief: Refusing to provide health services (2012). *The Guttmacher Institute.* Retrieved March 9, 2012, from http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf

Utah Administrative Code (2011). Rule R277-474 School Instruction and Human Sexuality. Retrieved September 27 2011 from http://www.rules.utah.gov/publicat/code/r277/r277-474.htm

APPENDIX A

STUDY 1 QUESTIONS

1. Please take a few moments and say out loud the contraceptives of which you are aware.
    a. When do people use these contraceptives?
    b. How do people decide about the methods to use?

2. What influences your decision about using contraceptives?
    a. Who?
    b. How?
    c. Why?

3. Do economic factors impact your decision to use contraceptives?
    a. How?

4. Have you considered using long term contraception?
    a. If so, what have you considered?
    b. If not, why not?

5. Were you using a long term method when you came in for EC?
    a. Would you consider a more long term plan for contraception?
    b. Would any of the following be an issue for you?
        i. Cost?
        ii. Convenience?
        iii. Planning for a pregnancy?

6. Have you considered using the IUD before?
    a. Have you considered using the contraceptive implant?
    b. Why/Why not?

7. What have you heard about emergency contraception?
    a. Have you ever used emergency contraception?
    b. Which ones have worked the best for you?
    c. Why?
    d. Would you consider using an IUD for emergency contraception?

e. Would you consider using PlanB for emergency contraception?
f. Why/Why not?

8. How have you obtained information about emergency contraceptives?
    a. Who gave you the information?
    b. Is it accurate?
    c. How do you know the information is accurate?
    d. Were there any barriers to obtain this information?
        i. Support from people in your life
        ii. Finances
        iii. Physical Health

9. What would being pregnant mean to you?
    a. How would being pregnant fit with your view of yourself right now?

APPENDIX B

STUDY 2 QUESTIONS

1. When you have discussions about EC, which patients do you discuss it with?
    a. Everyone?
    b. Only those who engaged in unprotected sex?

2. How is the copper IUD viewed by your patients?

3. How do you view IUDs as a form of EC?
    a. When do you recommend the use of the copper IUD as form of EC?
    b. When do you discourage the use of the copper IUD as a form of EC?

4. What are your experiences inserting an IUD as a form of EC?

5. The IUD doesn't always go in. What makes you stop at an insertion?
6. What do you do following a failed insertion?
    a. What does a patient do?

7. What do you think you could do to accomplish difficult IUD insertions?
    a. What have you heard others do?

APPENDIX C

STUDY 3 QUESTIONS

1. What is your experience with emergency contraception?
    a. How did the experience/would an experience affect you?

2. When do you decide to use contraception?
    a. When do you decide not to use it?

3. What happens after your method fails?
    a. What happens if you don't use a method?

4. What is EC?
    a. What do you know about EC?
    b. What do you think about EC?

5. What do you know about the copper IUD?
    a. Long-term methods of contraception?

6. Whose decision is it to use EC?

7. Has your partner ever used EC?
    a. Which method?
    b. What happened?
    c. Would you recommend EC to partner after unprotected intercourse?

8. What do you think about people who use EC?

9. How do you feel about EC?
    a. How do you think your partner feels about it?
    b. Why?

10. How do you think your relationship influences decisions around EC?
    a. Contraception?